

103

HEALTH CARE REFORM

Y 4. W 36: 103-5

Health Care Reform, Serial No. 103-... **ARINGS**

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

VOLUME I

Current Trends in Health Care Costs and Health Insurance Coverage

JANUARY 26, 1993

Overview of CBO Scoring for Cost Savings Under Reform Proposals

FEBRUARY 2, 1993

Economic Impact of Rising Health Care Costs

MARCH 2, 1993

Serial 103-5

Printed for the use of the Committee on Ways and Means



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CURRENT TRENDS IN HEALTH CARE COSTS AND HEALTH INSURANCE COVERAGE

TUESDAY, JANUARY 26, 1993

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, D.C.***

The subcommittee met, pursuant to call, at 10:35 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 15, 1993

PRESS RELEASE #1
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM: CURRENT TRENDS IN HEALTH CARE COSTS
AND HEALTH INSURANCE COVERAGE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing focusing on current information on health care costs and health insurance coverage.

This will be the first of a number of hearings on health care reform which will be held by the Subcommittee. This hearing will be held on Tuesday, January 26, 1993, beginning at 10:30 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing this hearing Chairman Stark said: "This hearing will focus on the basic health issues which the Subcommittee will address this year as we work with President-elect Clinton to enact health care reform legislation. An early start on these hearings will help us move quickly once the President's plan is sent to the Congress."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

Health care costs are increasing rapidly, at more than 12 percent a year, more than 8 percent more than the rate of general inflation. Health care is consuming an ever larger proportion of the Gross Domestic Product (GDP) and reached 13.6 percent of GDP in 1992.

The United States spends far more on health care as a percent of its economy than do any of the Nation's major trading partners. Canada now spends 9 percent of GDP, while Germany spends 8 percent, and Japan 6 percent. While health as a portion of the GDP remains relatively constant for many countries, in the United States health is expected to exceed 18 percent of GDP by the end of the decade.

Rising costs are driving up health insurance premiums by more than 15 percent each year. At the current rate of increase, health insurance premiums will double every four years.

There are an estimated 35.4 million Americans without health insurance. More than 80 percent of the uninsured are workers or dependents of workers.

The hearing will present expert testimony from the Congressional Budget Office on the current status of health care costs, including current rates of growth, and expected future expenditure levels, absent action to control costs. The Chairmen of the Prospective Payment Assessment Commission and the Physician Payment Review Commission will present testimony on the causes of rising costs, and will review possible strategies for containing costs.

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Testimony will be presented regarding the extent of health insurance coverage in the population, the current number of uninsured, and the characteristics of the uninsured population.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, February 9, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. Good morning. Today we are going to begin our work on health care reform through the first of a number of hearings on basic health financing and coverage issues. I hope these hearings will lay the foundation needed to help us as we work with our new President to enact health care reform legislation. Today we will examine the problems of rising health care costs and the lack of coverage for too many Americans.

The critical need to assure health insurance protection or a payment plan for every American demands our best efforts and highest priority. Improved coverage for the 35 million uninsured Americans is likely to be a central and critical component of any health plan.

As we will hear later this morning, the number of Americans without health insurance has increased by about 1 million individuals—each year—since 1988. Over the course of a 2-year period, over 60 million people experience at least 1 month without health insurance.

The problems of coverage are not restricted to those without insurance. Each of us is acutely aware that a medical problem could result in “job lock,” or the absence of health insurance coverage at some time in the future when we need it most.

We dread, with good cause, the threat of being labeled medically uninsurable, and we also dread the possibility of going bankrupt should we be selected to become ill.

The private health insurance system seems to be afflicted with a use-it-and-lose-it kind of mentality. It spends all its time identifying how to exclude people who might incur health care costs and not enough time controlling those skyrocketing health care costs.

Today, we will examine trends in health expenditures. It would be virtually impossible, as well as irresponsible, to expand coverage if we cannot control the escalating growth in health care spending. Rising costs are taking too big a bite from the Federal, State, corporate, and individual budgets. And each of us knows how that can impact middle class American families whose wages aren't adequate to cover all of their needs. Health care costs are rising at the rate of 11 percent a year. That is about 8 percentage points higher than the overall rate of inflation.

With employers reporting double-digit health insurance premium increases each year, the health benefits which American workers have already earned are in jeopardy. There is no question that increasing health care costs are directly reducing the take-home pay of America's workers.

Rising costs are driving up health insurance premiums by more than 15 percent a year. At this rate, health insurance premiums will double every 4 years.

The increase in health insurance premiums is leading management to propose benefit restrictions which would have been unthinkable 10 years ago. In some cases these changes lead to decreases in coverage for workers and their dependents, including outright termination of dependent coverage.

The United States spends more on health care than its major trading partners, without commensurate gains in health status. Controlling health care costs is an important part of our strategy to assure our Nation's international competitiveness.

Today the subcommittee will begin to examine these problems in detail. Our distinguished group of expert witnesses will help us lay the groundwork for future discussion of the President's health reform proposals. I look forward to their testimony.

Before we begin, I have a sad duty and a happy duty. First, the happy duty is to introduce all of you to our new ranking member, my distinguished colleague from the great State of California, Bill Thomas. But before I recognize Congressman Thomas, I would also add the sad duty. We only have a few more days with our distinguished colleague from Ohio, Bill Gradison, who has suffered through these hearings at my left hand for 8 years and who will be greatly missed. He will soon be out in that audience continuing to effect health care policy, I am sure.

And, Bill, we will miss you.

I would also like to welcome the only new member of the committee who is on time, Congressman Kleczka from Milwaukee, Wis., We are looking forward to his participation.

We will introduce the other new members, including Mike Andrews, our distinguished colleague from the State of Texas, as they arrive.

At this point, I would be happy to recognize Congressman Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I hope I don't suffer at your left hand. I know that is the much stronger of the two.

I appreciate the opportunity to participate in what I think is going to be one of the major thrusts of this administration, and I am pleased to say that we, as Republicans, are hoping that we can be full partners in solving a problem that all Americans believe needs to be solved.

The jurisdiction of our subcommittee covers most of the very complicated and pressing issues that face this Congress, although I do believe that the jurisdiction of other committees, at least in the House, contributes as much to the problem of solving it as we move into the various components and that, I think, needs to be addressed if we are going to address the "health care problem at large."

Personally, I come to the hearings with very few biases, and that is possible because I have very little information available to me. I knew enough about this subject matter to perhaps think about introducing a bill or two on it. As you know, most often what you do when you don't know a whole lot about a subject matter is to introduce a bill, tell people what they should do, and then leave to them the difficulty of actually producing documents that are to become law.

I have been sobered by the new position, and I have withdrawn my bills, and I am willing to participate in the process hopefully to produce law. I was encouraged by Secretary Shalala's statement to the press yesterday that they aren't going to take anything off the table. I think if we are going to come to a solution of this problem, none of us can take anything off the table. We have to be willing to examine some syllabus, as well as some realities, and understand that the solution is going to require contributions from everyone.

I think, though, that to establish some guidelines going in—since a lot of folks perhaps don't know me—I think some guiding princi-

ples will be utilized by me. I don't think they are biases. I think they are principles.

The first one is that I do believe for us to be successful, we have to be comprehensive. I simply do not believe that incrementalism at this, stage one, is going to produce a solution which will actually solve the problem or be lasting.

Secondly, if we don't approach it in a comprehensive way, given the pressures in this business, we are going to go halfway and not accomplish what we need to accomplish. Also, it seems to me that one of my real goals will be to produce a system, if at all possible, in which Government does what I believe it does best, and that is basically oversee and referee rather than micromanage. I think it will be a failure if we set up a system in which the Government's charge is to be responsible in a central way for decisions that should be made elsewhere.

Thirdly, I think it provides an enormous opportunity for us to examine the single largest and fastest growing areas of Federal expenditures. As we address the health care problem, if we address entitlements, I think we can at the same time focus on the deficit. I think entitlements need to be reexamined and reconsidered.

And, finally, I think we will also fail, no matter which direction this initiative takes, if we don't present the problem and offer the solutions in such a way that Americans as individuals will realize that they are an integral part of this problem; that we need to educate Americans, not just in terms of their own personal choices, either in terms of an economic or a health question, but that by their failure to fully understand the role that they need to play in the system, we will not have accomplished the kind of sweeping fundamental change that I think is necessary to right the United States in its health care course, and that is, that the American consumer, participant, and taxpayer is fundamental to making the system work.

I think for too long they have been more ignorant than they should have been, one, about where the money came from, where the money goes, and their failure to make prudent decisions. When something is free, it is always difficult to exercise prudent decisions. We all know it is not free, but many of them, unfortunately, believe it is. I am appalled at polls that show that most Americans believe that the way we can solve the problem is to squeeze out waste, fraud, and abuse, and that is all that is necessary.

So I am looking forward to this endeavor. I don't think it is going to be easy. I am pleased that the administration has placed this, if you will, on the front burner with one of the major chefs in the new administration overseeing the operation, and I am very hopeful that the results of this process will solve a concern that not just those Americans without health insurance feel strongly, but those with what would appear to be perfectly adequate health insurance worry about as well—that is, that they may have it today, but what about tomorrow. I think we need to look at both today and tomorrow, Mr. Chairman, and I look forward to these hearings. Thank you very much.

[The prepared statement follows:]

STATEMENT OF HON. BILL THOMAS, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF CALIFORNIA

Mr. Chairman, I appreciate your scheduling this introductory hearing, as well as other such hearings to follow. As the new ranking member of the Ways and Means Health Subcommittee, although no stranger to health issues, going "back to the basics," will provide a useful orientation.

The jurisdiction of our Subcommittee covers some of the most complicated and pressing issues facing this Congress. Over the coming months our success in meeting the challenges before us will depend in part on our gaining a common understanding of this nation's health care. These hearings will enable us to accomplish that goal.

Mr. Chairman, the members of this Subcommittee will be asked to accept a huge task in the upcoming months. Americans are deeply concerned about the availability and cost of health care. Many of my own constituents are just plain afraid that their health care is threatened.

This heightened sensitivity clearly made health care an issue for all of us in the election last November. So, both the President and 103rd Congress have a mandate for reform.

If the challenge of this mandate is to be met by the Congress, this Health Subcommittee, as the full Ways and Means Committee, will be on the front line.

Health reform will test this Committee. Our ability to work together towards a common end may determine the ultimate success or failure of the health reform process.

Personally, I come to this process with few biases, and sincerely hope that we all are open to explore every possible

option. As the new Secretary of Health and Human Services, Donna Shalala told the press yesterday, following a briefing with the President, and I quote, "certainly we didn't take anything off the table..."

Mr. Chairman, as we begin today, we should also take nothing off the table.

However, from my standpoint we should recognize certain principles:

- o First, reform must be comprehensive. We need to give the public a vision of the future, and then address the broad spectrum of problems facing health care in America.
- o Second, reform should task the government to do what it does best, act as a referee not a micro-manager. If reform means the federal government will set the price for band aids and watch over every physician's shoulder, then the process is destined for failure.
- o Third, the future of the federal entitlements must be reconsidered. These programs must be made more affordable, while assuring our commitment to those Americans who are in greatest need.
- o Finally, whatever form our initiative takes, it should promote greater participation in health care decision making by individual Americans. Unfortunately, the average American with health coverage has come to look upon medicare care as a free good. Reform must make all of us responsible, cost conscious partners in the purchasing of our health care. Otherwise, lasting health care cost containment will be impossible to accomplish.

Mr. Chairman, I look forward to the endeavor upon which we embark today. I am confident you and I and our colleagues on the Ways and Means Committee can get the job done, and pass onto this Congress a health reform package in which we all can take pride.

Chairman STARK. Thank you.

Mr. Kleczka.

Mr. KLECZKA. Mr. Chairman, I have no opening statement except I would like to recognize you for hosting the forum yesterday which was held at Fort Myer. The absence of the new members on our side made me think that they all understood everything that was discussed yesterday and are probably drafting legislation, and I was a slow study and had to come back for more, but clearly that is not the case.

Mr. Chairman, I think we all recognize what the problems are in our current health care system. As we go through the panels today, we are going to find out more of those problems, but hopefully we will also discuss some realistic solutions. This is going to be an arduous task, and I look forward to working with the subcommittee and the full committee in coming up with a resolution that the American people will find reasonable and justifiable. Thank you.

Chairman STARK. Mr. Andrews.

Mr. ANDREWS. Thank you, Mr. Chairman, and the only thing I would add to this is I do think the most critical domestic issue of our time is reforming the health care system, and probably the greatest domestic challenge the new administration and the new Congress face is how to reform the system. And it may not—may be 1993, but in terms of health care and in terms of the kind of dramatic change in leadership that is necessary, it might as well be 1933 because I think only the most creative and inventive kind of change is going to affect our policy for decades to come. And I mean by that, I think a piecemeal approach is not going to work, and I think we have to put aside a lot of old positions we have taken, partisan positions, positions that I think are outmoded to the future and the next century; and we really have to work in a very bipartisan way.

The solution, I really believe, will be dramatic; it will be profound. It has to be all encompassing, and it will be a bipartisan solution if we are truly going to change policy, and I am certainly committed to that.

We all represent different views. I support the concept of managed competition. Others on the subcommittee feel strongly about the positions that they hold. Through these hearings and these debates, hopefully working hand in hand with the President and his task force and the Secretary of HHS and others, we will be able to come up with a proposal and a plan that the American people are going to support.

Chairman STARK. Thank you. And before I, again, recognize Mr. Thomas, I wanted to acknowledge another new member, Congressman John Lewis, from Atlanta, Ga. We are pleased to have him with the Health Subcommittee.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I would just like to mention that returning to the panel are Nancy Johnson of Connecticut and Fred Grandy of Iowa, but that new to both the committee and the subcommittee is Jim McCrery from Louisiana, whom I have worked with extensively when we were both on the Budget Committee, and it is a real pleasure to have him with us. But at this

time, if the chairman would allow me, I would allow Nancy Johnson to——

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thanks. I want to thank the chairman for initiating this series of hearings.

I just want to say, as we start this subject—and most of us in the room here, at all parts of the room, have been working on this subject now for a couple of years, and we know it to be a complex issue—we are going to tinker with almost 15 percent of our economy, all of the money and jobs associated with that sector and with the highest quality health care system in the world.

I share the goals of my colleagues here on the committee and on the larger committee of creating a health care system that provides universal access to affordable care. But I am keenly aware of the danger of unintended consequences, of the—the possible unintended consequences of our actions. So one of the standards to which I am going to hold my thinking—and I urge all of you here to help me do so—is a sort of reality test.

Are the changes we are proposing changes that we have some reason to believe will work? In other words, concrete experience to indicate that this change will have a positive effect, rather than negative effect. I fear theology in health care reform and because we are such a diverse nation, diverse people, live in diverse circumstances, it is going to be extraordinarily important for us to hold ourselves to the discipline of examples that have worked, of principles that have functioned well in our society, and connect specifically and deeply into the values that have made us a great and strong Nation.

So I look forward to these working months with you, Mr. Chairman, and my ranking member, and all of you out there. We certainly are attacking the fundamental problem that underlies not only an important social problem, but our budget problems as well. Thank you.

Chairman STARK. Thank you.

Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. Chairman, I am pleased to be here this morning at my first hearing as a member of the Subcommittee on Health. We all know that we have a lot of work before us today and in the weeks and months to come. I look forward to hearing the testimony from the panelists, and I am ready to begin the work on this very important task. I think the American people want us to come up with a comprehensive, universal system. The people are saying that we must do something. There is a sense of urgency.

I think we must break with the past and be bold, be aggressive, and develop a system that we all can buy into and share with the American people.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. I appreciate the fact that you are holding these hearings. I think health care reform is one of the most important issues to be dealt with in this term of Congress. These hearings are extremely important to help bring this commit-

tee, indeed the people of this Nation, can come together on a health care reform bill that will provide universal coverage to affordable, quality health care

Mr. Chairman, I took this time, though, to point out, as you did, that our job is going to be more difficult in this committee because of the loss of Bill Gradison. I know Bill, this is your last meeting with us. It has been a real honor to serve with you in the Congress. You have been a real help to me, and I think to the entire system here, in the way that you brought people together and worked with us all. I wish you well. I personally am going to miss you, and I know that Congress is going to miss your leadership in helping to bring together this important issue.

Chairman STARK. Are there other members who have a statement?

Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

Bill, so long. We are sorry you are leaving. And that isn't just pro forma. It has been a real privilege to work with you, and it is sad you are leaving because I think it is a new day for health reform. I think the time for talk is over and the opportunity for reform is at hand; and this subcommittee will have a key role to play with the new administration.

Where I come from, the impatience with inaction has reached very vivid proportions. We held town meetings 2 weeks ago. Health care reform was at the top of the list and there was restlessness, indeed impatience, indeed some anger that we weren't responding in the past. So, Mr. Chairman, I think the days ahead will be exciting ones and challenging ones, and my guess is that when we reconvene here a year from now, there will be a health care—a health reform law in place. I hope so.

Chairman STARK. Thank you. Any other members?

If not, we will begin with our testimony from the guardians of the public purse, the Congressional Budget Office, ably represented by Nancy Gordon, Assistant Director of Human Resources and Community Development, who is accompanied this morning by Kathryn Langwell, who is Deputy Assistant Director for Health and Human Services in the Community Development Division, and Murray Ross, who is the Principal Analyst for the Health, Human Resources and Community Development Division.

Welcome again to the committee.

Dr. Gordon, why don't you proceed to enlighten us? As with all witnesses today, your prepared remarks, without objection, will appear in the record in their entirety. You may expand on that testimony or paraphrase it. Proceed as you desire.

STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION, ACCOMPANIED BY KATHRYN LANGWELL, DEPUTY ASSISTANT DIRECTOR FOR HEALTH, AND MURRAY ROSS, PRINCIPAL ANALYST FOR HEALTH, CONGRESSIONAL BUDGET OFFICE

Ms. GORDON. Thank you very much, Mr. Chairman. I appreciate the opportunity to appear before this subcommittee. My task today

is to discuss trends in the number of people without insurance and in the costs of health care.

I think it is important to begin, however, by observing that the U.S. health care system has many strengths and provides the highest-quality care in the world. In the U.S. system, many people have access to care without waiting, and few limits are placed on the choice of providers, alternative treatments, or types of health coverage.

Yet as many of you have noted, criticism of the health care system has been growing. First, substantial numbers of people lack health insurance, and as a result they receive fewer health care services than those who are insured.

Second, health care spending per person is much higher in the United States than in other countries and is rising faster than the gross domestic product.

I would like to proceed this morning by discussing the tables and figures that are at the back of my testimony and also in a separate handout given to the members.

Table A-1 examines health insurance coverage for that part of the population under age 65. As the table indicates, 35.2 million people were without health insurance last year. That number represents about 15.9 percent of the nonaged population. The right-hand column of the table brings out the importance of employment-based coverage: 67 percent of the nonaged population had that type of insurance.

Table A-2 describes the uninsured. The column titled "Percentage of Uninsured People" shows, for example, that more than 60 percent of the uninsured had incomes below 200 percent of the poverty level. Continuing down the column, you can see that although more than three-fourths of the uninsured were white, blacks and people of other races were much less likely to have insurance than were whites.

To understand our health care system, one must know why employment-based insurance is so common. In large part, the answer can be found in the Tax Code. In particular, excluding the part of the premium that employers pay from the taxable income of employees means that many employees can obtain a dollar's worth of health insurance at a marginal cost of only 52 cents of after-tax income.

Despite these subsidies, however, not all employees receive health insurance coverage through their employment. In fact, table A-3 shows that most of the uninsured are connected to the work force: either they are employed or some other member of their family is employed. Again, the column titled "Percentage of Uninsured People" shows that only 27 percent of the uninsured had no connection to the work force. But only about half of the uninsured had a full-time connection to the work force. This fact is, of course, important, because part-time employees generally are not eligible for health insurance.

A major factor affecting the availability of employment-based insurance is the size of the employing firm. Table A-4 shows that only 39 percent of firms with fewer than 25 workers offer insurance, whereas virtually all firms of 100 or more workers do so. One

reason that small firms are less likely to offer insurance is that the administrative costs associated with small groups are quite high.

Turning now to spending for health care, in 1991, the United States spent \$752 billion on health care, or about \$2,900 per person. Figure A-1 shows that the level of spending by the United States is considerably higher than that of a number of other developed countries. In 1990, for example, the United States spent 12.4 percent of its gross domestic product on health, compared with spending of 9 percent by Canada and 8 percent by the former West Germany. These higher costs in the United States affect individuals, providers, and governments.

As health spending has risen, its distribution by payer shown in figure A-2, has also changed. The most striking feature is the drop in the proportion of personal health spending that people pay out of pocket; it goes from more than 50 percent in 1965 to 22 percent in 1991. In contrast, the share paid by private insurers and governments has increased.

Figure A-3 indicates that even though household spending on health care has declined as a share of total health expenditures, it has been relatively stable as a percentage of income—around 3.5 percent since 1984 for nonaged households and about 11 percent for households headed by a person age 65 or older.

Efforts to control health care costs have focused on hospital spending, but these attempts have had only limited success. And although some hospitals have had financial problems, in part as a result of these cost containment policies, figure A-4 shows that average hospital margins remained at higher levels in the 1980s—more than 4.5 percent each year—than in preceding decades, when they averaged 2.4 percent between 1965 and 1975.

Spending for physician services increased even more rapidly in the 1980s than did spending for hospital services, and physicians' incomes, after expenses, rose more than 31 percent after accounting for general inflation during this period. Figure A-5 presents another aspect of these data: U.S. physicians generally earned considerably more than their colleagues in other countries.

Turning to table A-5, we can see the implications for the Federal budget of the rapid growth in national health expenditures. In 1970, spending on health constituted only 7 percent of the Federal budget, but by 1992, it had risen to 16 percent. Even more disturbing is the Congressional Budget Office's (CBO) projection, which is being released today with other Federal budget estimates, that health care will account for almost 24 percent of Federal spending by 1998. Medicare and Medicaid are major components of this total; taken together, they make up about 85 percent of Federal spending on health. Moreover, they are both growing more rapidly than the other health programs—about 10 percent a year above the rate of general inflation, compared with only 2.5 percent above inflation for the other programs.

The bottom half of figure A-6 shows that, after growing much more rapidly than national health spending per capita in the 1970s and the first half of the 1980s, Medicare's growth per enrollee fell to 3.1 percent in the second half of the 1980s. This rate is considerably less than the 4.8 percent rate of growth in per capita expenditures overall.

Most of this decline in growth, as figure A-7 indicates, stemmed from the substantial drop in the late 1980s: the rate of increase in Medicare spending per enrollee for hospital services. However, the rate of growth of national spending per capita for hospital services was quite stable during the 1980s. This pattern illustrates a significant factor in our inability to gain better control over spending for health care. In our multiple-payer system, successful efforts by one payer to reduce the growth in costs appear to be offset by more rapid increases in costs for other payers.

In conclusion, despite the many strengths of this Nation's health care system, a growing number of people are uninsured, and efforts to control costs have been unsuccessful. Addressing these problems is a formidable task. Solutions that would reduce the number of uninsured people would, by themselves, raise the costs of care. Controlling these costs without ensuring that everyone has health insurance would probably reduce access to care for the uninsured. Yet without substantial changes in our health care system, it is almost certain that more people will be without insurance and that the cost of health care will continue to rise rapidly.

Thank you, Mr. Chairman; that concludes my statement. I would be pleased to answer any questions.

[The prepared statement and attachments follow:]

STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR, HUMAN
RESOURCES AND COMMUNITY DEVELOPMENT DIVISION,
CONGRESSIONAL BUDGET OFFICE

Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss trends in the number of people without insurance and the costs of health care.

OVERVIEW OF THE HEALTH CARE SYSTEM

The U.S. health care system has many strengths. Because of the resources devoted to research and because our current financing system encourages the rapid dissemination of new technologies, we are able to provide the highest quality care in the world. The substantial majority of the population—generally, those with health insurance—have access to care without waiting, and there are few limits on our choices of providers, alternatives for treatment, or types of health coverage.

Yet, over the past two decades, criticisms of the health care system have grown: substantial numbers of people remain without health insurance, either private or public, and health care spending per person is much higher than in other countries and is rising faster than the gross domestic product (GDP). Moreover, unless the system is modified substantially, we may anticipate further deterioration of insurance coverage and continued rapid increases in spending for health care.

TRENDS IN INSURANCE COVERAGE

In March 1992, about two-thirds of the population under age 65 had health insurance through an employment-based group, either because their own employer offered it or because they were insured as a dependent of a worker whose employer offered group coverage (see Appendix Table 1). Another 10.5 percent of the nonaged population was insured through a public program—Medicaid (8.7 percent), Medicare (1.4 percent), or the Department of Veterans Affairs (0.3 percent). Another 6.5 percent was insured through individual insurance policies unrelated to employment. The remaining 15.9 percent of the nonaged population—about 35.2 million people—were without insurance coverage. (Because almost all of the elderly participate in Medicare, they make up a negligible proportion of the uninsured.) Since 1980, the proportion of the population under 65 without health insurance has increased by more than one-fourth.

Three-fifths of the uninsured had incomes less than 200 percent of the poverty level (see Appendix Table 2). Children were less likely than others to be uninsured—12.7 percent of children were uninsured versus 17.3 percent of the population aged 18 to 64. Moreover, although white people account for more than three-quarters of the uninsured, nonwhite people are much more likely to lack coverage.

Employment-Based Insurance

Excluding employer-paid fringe benefits from the taxable income of the employee encourages reliance on employment-based group insurance to provide financial protection against health care costs. For example, an employee with a marginal federal income tax rate of 28 percent, a federal payroll tax rate of more than 15 percent, and a state income tax rate of 5 percent can obtain \$1 worth of health insurance coverage paid by an employer

at a marginal cost to the employee that is equivalent to about 52 cents of after-tax income.

Excluding the employer-paid share of health insurance from taxable income will provide an implicit federal subsidy for group insurance of about \$70 billion in 1993. Similar provisions in state income tax codes will provide about \$10 billion in implicit subsidies annually. Despite these subsidies, not all employees receive health insurance coverage through their employment. About three-quarters of the uninsured are in the workforce or are in a family where at least one person is employed (see Appendix Table 3). The remaining uninsured have no family connection to the employed labor force.

A major factor affecting the availability of employment-based group insurance is the size of the employing firm. Only 39 percent of firms with fewer than 25 workers offer insurance, whereas virtually all firms with 100 or more workers do so (see Appendix Table 4). One reason that small firms are less likely to offer insurance may be that the administrative costs associated with small groups are quite high. Firms with fewer than 50 employees face administrative costs of at least 25 percent of the cost of benefits, compared with 12 percent or less for groups with 500 or more employees.

Regardless of their size, firms that do not offer health insurance have substantially higher proportions of low-income workers than firms that do offer it. In addition, the decline in the proportion of full-time workers with employment-based health insurance—from 77.2 percent in 1982 to 73.8 percent in 1987—appears to have primarily affected low- and moderate-wage workers. With health care costs rising much more rapidly than wages, this gradual erosion of health insurance coverage is likely to continue. It may be offset in part, however, by Medicaid eligibility continuing to expand, which will occur through the beginning of the next century.

Consequences of Being Uninsured

People without insurance use fewer services than do the insured, and although some of the forgone services may be of limited value, important ones are apparently also not obtained. A recent study of five medical procedures that are expensive and have a substantial discretionary element found that, among the hospitalized, those without insurance were 29 percent to 75 percent less likely to undergo the procedures, even though the uninsured were sicker when they were admitted. Uninsured patients were also significantly more apt to die in the hospital, even after one adjusts for factors such as their poorer health. Clearly, the consequences of being uninsured can be severe, both for the individual and for society.

TRENDS IN SPENDING FOR HEALTH CARE

In 1991, the United States spent \$751.8 billion on health care—or about \$2,870 per person. The annual rate of increase in per capita spending, adjusted for general inflation, between 1980 and 1991 was 4.5 percent. CBO's projections suggest that, by the year 2000, per capita spending on health care will exceed \$4,600 (in 1991 dollars). This country already spends much more on health than do other developed countries, both in absolute dollars and as a share of national income—12.4 percent of gross domestic product in 1990, compared with 9.0 percent in Canada, 8.1 percent in the former West Germany, 6.5

percent in Japan, and 6.1 percent in the United Kingdom (see Appendix Figure 1).

As health spending has risen, its distribution by payer has also changed. The share of personal health spending that people pay out of pocket declined from 53.4 percent to 21.9 percent between 1965 and 1991. In contrast, private insurance payers and governments have taken on an increasing share. Private insurance accounted for 24.3 percent of health spending in 1965 and 31.7 percent in 1991; federal, state, and local governments paid for 20.3 percent in 1965, before Medicare and Medicaid were in place, but 42.9 percent in 1991 (see Appendix Figure 2).

Impact on Consumers

Even though household spending has declined as a share of total health expenditures, it was relatively stable as a percentage of income—around 3.5 percent over the 1984-1991 period for nonaged households. In contrast, households headed by a person aged 65 or older spent around 11 percent of income on health care (see Appendix Figure 3), and other evidence suggests their out-of-pocket spending, relative to after-tax income, has risen substantially since 1972.

In fact, a small fraction of the population each year accounts for an exceptionally high proportion of total spending for health care. In 1987, the 50 percent of the population with the lowest health care bills accounted for only 2 percent of total spending on health, while the 10 percent with the highest expenditures accounted for 75 percent. This pattern holds for both the population under age 65 and for the aged population.

Impact on Providers

During the past decade, much of the effort to control health care costs has focused on hospital spending—both through managed care that attempts to control hospital admissions and lengths of stay and through Medicare's prospective payment system. Nevertheless, during that period hospital spending continued to rise. For example, in 1980 the United States spent \$169.5 billion (in 1991 dollars) on hospital care, compared with \$288.6 billion in 1991. This growth was the result of a striking 72 percent increase, after accounting for general inflation, in expenses per admission (adjusted for the growth in outpatient visits), which more than offset a 14.1 percent drop in admissions over this period.

Hospital margins based on total revenues, over the same period, also remained at higher levels than in preceding decades. Although hospital margins declined from 5.9 percent to 4.8 percent between 1985 and 1990, they rose to 5.2 percent in 1991, compared with an average of 2.4 percent between 1965 and 1975 (see Appendix Figure 4). Despite the evidence that hospitals are on average more than covering their costs, some hospitals, including many that serve a high proportion of uninsured and Medicaid patients, are losing money.

Spending for physician services increased even more rapidly than spending for hospital services over the past decade. In 1980, the United States spent \$295 per person (in 1991 dollars) on physician services; by 1991, the country was spending \$542 per person—an 84 percent increase in real spending per person over an 11-year period.

Physicians' incomes, after expenses, also rose during the 1980s—more than 31 percent, after accounting for general inflation, between 1981 and 1989. In 1986, U.S. physicians earned considerably more than their colleagues in other countries, both in absolute and in relative terms—around 50 percent more than physicians in Canada and West Germany, and three times as much as physicians in the United Kingdom. That year, U.S. physicians earned 4.5 times the average compensation of all U.S. workers, higher than the value in the other countries compared (see Appendix Figure 5).

Impact on the Federal Budget

The rapid growth of national spending for health care, overall and per capita, also has significant implications for the federal budget. In 1970, spending on health constituted 7.1 percent of the federal budget. By 1992, that share had grown to 16.1 percent. Even more disturbing, in its January 1993 federal budget baseline projections, which are being released today, CBO projects that health care will account for 23.6 percent of federal spending by 1998 (see Appendix Table 5).

After taking general inflation into account, CBO projects that federal Medicaid expenditures will rise at an average annual rate of 10.6 percent between 1992 and 1998. The corresponding growth rate projected for Medicare is 9.4 percent. In contrast, all other federal health expenditures are projected to grow at only 2.5 percent.

The annual rate of real growth in Medicare spending per enrollee was also substantially higher than growth rates in health spending per person in the nation throughout the 1970s and in the first half of the 1980s. But Medicare's real growth in spending per enrollee between 1985 and 1991 fell to 3.1 percent—a figure considerably less than the 4.8 percent growth in per capita expenditures the nation experienced (see Appendix Figure 6).

Most of this decline in growth stemmed from a substantial drop in the rate of increase in Medicare's spending for hospital services. Although the real rate of growth in physician spending also declined somewhat, it continued at a 5.6 percent annual rate per enrollee during the 1985-1991 period, compared with 1.0 percent for hospital spending (see Appendix Figure 7).

The average annual real rate of growth of per capita spending for hospital care in the nation, however, has been essentially stable over the 1980-1991 period, even though the rate of growth in Medicare's spending dropped substantially. This pattern illustrates a major factor in this country's inability to gain better control over health spending. In the U.S. multiple-payer system, successful efforts by one payer to reduce the growth in costs appear to be offset by more rapid increases in costs for other payers.

CONCLUSION

Despite the many strengths of this nation's health care system, serious problems exist. The number of people without insurance is growing, and this trend is expected to continue as employers respond to rapid increases in premiums for health insurance by limiting coverage and as insurers attempt to limit risk by excluding firms and individuals with exceptionally high needs for health care. Those most likely to be uninsured are least able to afford the

health care they need--the poor not eligible for Medicaid. Exacerbating the problems faced by the uninsured are high and rapidly rising costs of care.

Health care costs are increasing far more rapidly than inflation and show no signs of abating despite the many attempts made to control costs by both public and private payers. In fact, CBO projects that health care will absorb at least 18 percent of GDP by 2000. Without a reduction in the rate of growth in health care spending, more people are likely to be uninsured, workers will receive lower increases in wages and salaries as more of their compensation is received in the form of health insurance, and federal spending for health entitlement programs will continue to rise more rapidly than any other component of the federal budget.

Addressing these dual problems of the nation's health care system is a formidable task. Solutions that would reduce the number of uninsured would, by themselves, raise health care costs. Controlling costs without ensuring health insurance for everyone would probably reduce access to care for the uninsured. Yet, without substantial changes in our health care system, it is almost certain that more people will be without insurance and the cost of health care will continue to rise rapidly.

TABLE A-1. HEALTH INSURANCE COVERAGE OF THE NONAGED POPULATION, BY SOURCE OF COVERAGE, MARCH 1992

Insurance Status and Source of Coverage	Number of People (Millions)	Percentage of Nonaged Population
Total	220.8	100.0
Insurance Status		
Insured	185.7	84.1
Uninsured	35.2	15.9
Source of Insurance Coverage ^a		
Employment-based	148.2	67.1
Other private	14.3	6.5
Public	23.2	10.5
Medicaid	19.3	8.7
Medicare	3.2	1.4
Veterans Affairs	0.7	0.3

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March 1992.

NOTES: Details may not add to totals because of rounding.

"Nonaged" refers to people under age 65.

a. "Source of Insurance Coverage" refers to the individual's primary insurance coverage when there are multiple sources of coverage.

TABLE A-2. CHARACTERISTICS OF THE NONAGED UNINSURED POPULATION, MARCH 1992

Characteristics	Number of Uninsured People (Millions)	Percentage of Uninsured People	Percentage of the Nonaged Population With These Characteristics Who Are Uninsured
Total Uninsured	35.2	100.0	15.9
Age			
Children under age 18	8.4	23.8	12.7
Young adults, 18 to 24	6.6	18.7	26.9
Adults, 25 to 54	17.6	50.0	16.1
Adults, 55 to 64	2.6	7.5	12.4
Income Level			
Below the poverty level	10.2	29.0	31.7
100 percent to 199 percent of poverty	11.3	32.2	28.3
200 percent of poverty and above	13.6	38.8	9.2
Race			
White	26.9	76.6	14.7
Black	6.5	18.4	22.4
Other	1.8	5.0	19.5

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March 1992.

NOTES: Details may not add to totals because of rounding.

"Nonaged" refers to people under age 65.

TABLE A-3. WORK FORCE CONNECTIONS OF THE NONAGED UNINSURED POPULATION, MARCH 1992

Characteristics	Number of Uninsured People (Millions)	Percentage of Uninsured People	Percentage of the Nonaged Population With These Characteristics Who Are Uninsured
Total			
Total Uninsured	35.2	100.0	15.9
Work Force Connection			
Employed	16.0	45.6	15.0
Dependent of Employed Person	9.5	27.2	12.9
No Work Force Connection	9.6	27.3	23.9
Employment Level			
Full-Time Worker	11.1	31.5	13.0
Dependent of Full-Time Worker	7.5	21.4	11.5
Part-Time Worker	4.9	14.1	23.3
Dependent of Part-Time Worker	2.0	5.8	22.8
None	9.6	27.3	23.9

SOURCE: Preliminary Congressional Budget Office calculations based on data from the Current Population Survey, March 1992.

NOTES: Dependents of employed people are: (a) their children under age 19 (or under age 24 if they are full-time students); and (b) their nonworking spouses. Dependents of full-time workers are in family health insurance units where either the head or the spouse works full time. Full-time work is defined as 35 hours or more per week.

Details may not add to totals because of rounding.

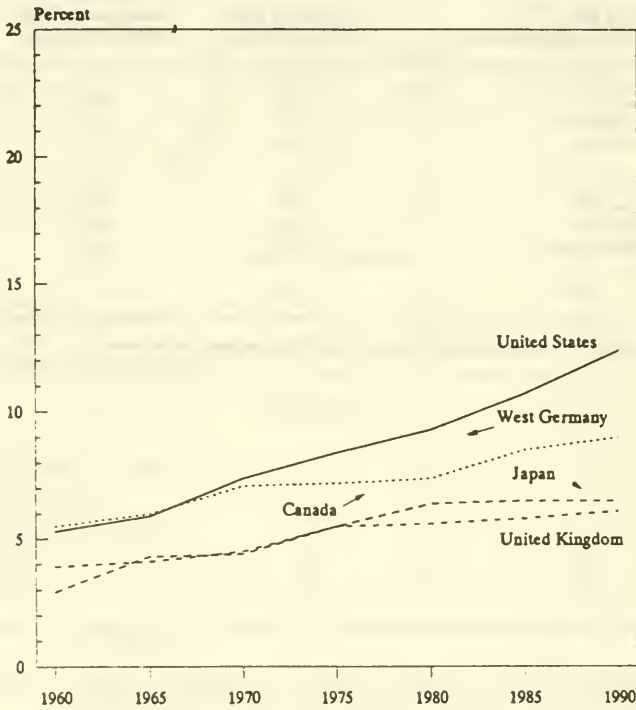
"Nonaged" refers to people under age 65.

TABLE A-4. AVAILABILITY OF EMPLOYMENT-BASED INSURANCE PLANS, BY SIZE OF FIRM, 1989

Size of Firm (Number of Employees)	Percentage of Firms Offering Insurance	Percentage of Employees in Firms Offering Insurance
Under 25	39	55
Under 10	33	42
10 to 24	72	70
25 to 99	94	94
100 to 499	99	97
500 to 999	100	100
1,000 and Over	100	100
Total	43	77

SOURCE: The 1989 Employer Survey by the Health Insurance Association of America.

Figure A-1.
Health Expenditures as a Percentage of Gross Domestic Product, United States
and Selected Countries, 1960-1990

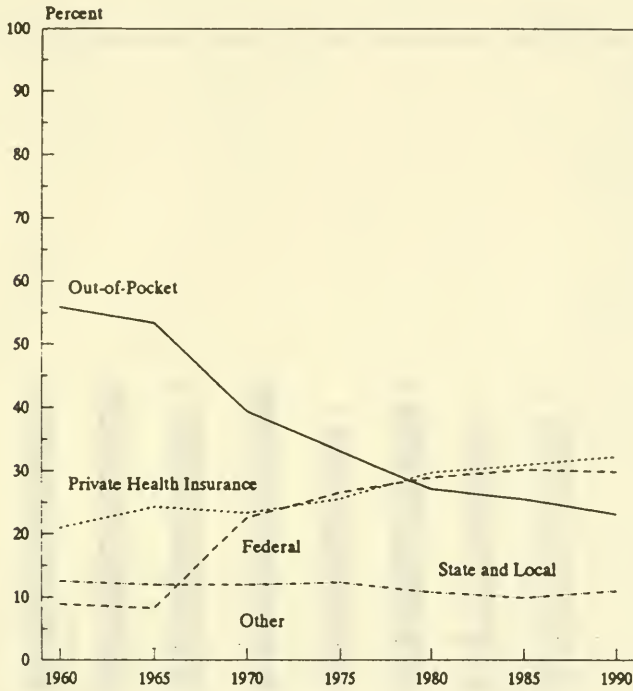


SOURCE: Congressional Budget Office using data from the Organization for Economic Cooperation and Development, Health Data File, 1991

NOTES: Gross domestic product is equal to gross national product less net property income from abroad. Use of gross domestic product for international comparisons of health spending eliminates variations arising from differences in the rate of foreign transactions in different economies.

Data are plotted at five-year intervals

Figure A-2.
Distribution of Spending for Personal Health Care, by Source of Payment, 1960-1990



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992.

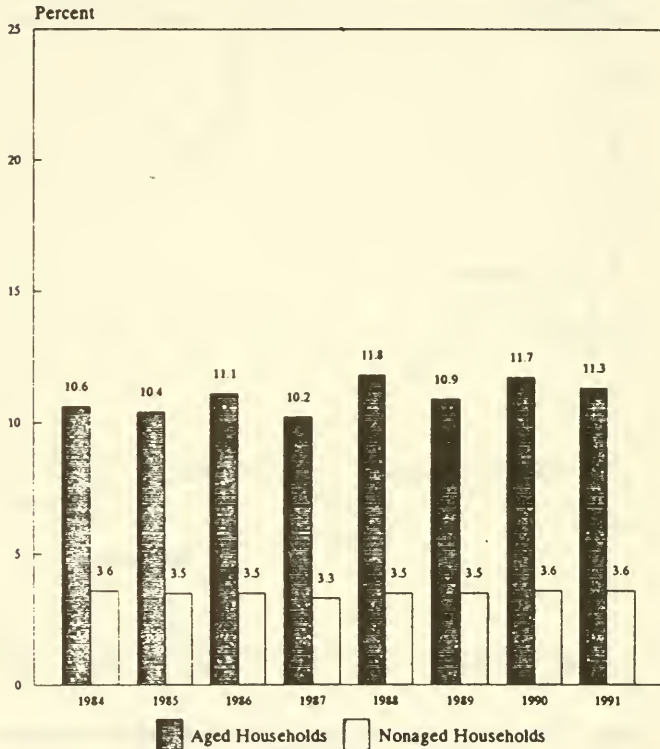
NOTES: Personal health care expenditures are equal to national health expenditures less spending for public health, research, construction, and administrative costs.

The "Other" category includes philanthropy and industrial in-plant spending for health.

Data are plotted at five-year intervals.

Figure A-3.

Direct Spending for Health as a Percentage of Income, by Aged Households and Nonaged Households, 1984-1991

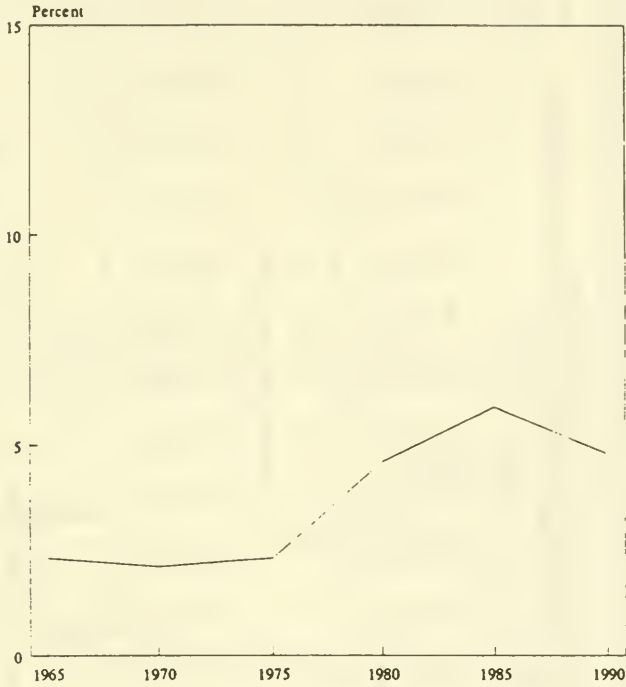


SOURCE: Congressional Budget Office calculations based on data from the Consumer Expenditure Surveys of the Bureau of Labor Statistics, 1984-1991.

NOTES: Data are tabulated by age of reference person. Aged households are those in which the primary owner or renter of the household is age 65 or over. Such households may include some individuals under age 65. Nonaged households are those in which the primary owner or renter of the household is under age 65.

"Direct spending on health" includes the amount directly paid for health insurance premiums by a household, as well as other out-of-pocket expenses for health services.

Figure A-4.
Hospital Margins Based on Total Revenues, 1965-1990

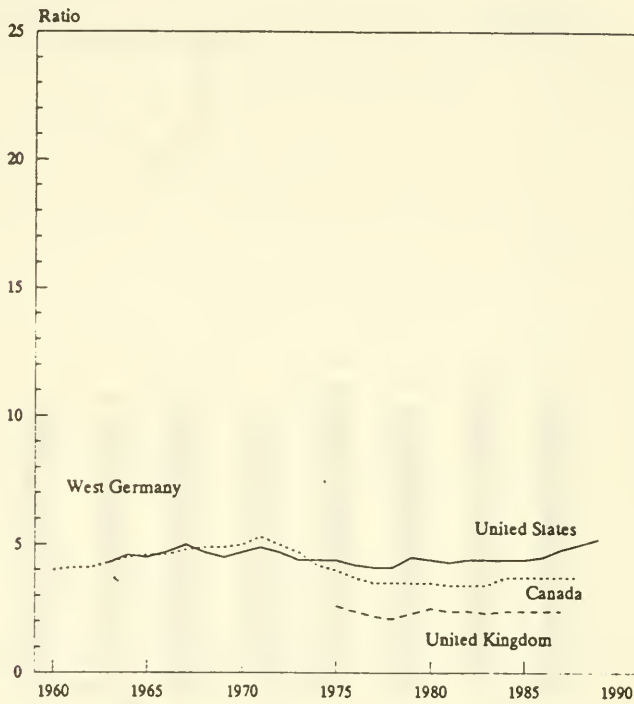


SOURCE: Congressional Budget Office calculations based on data from the American Hospital Association, National Hospital Panel Surveys, 1965-1990.

NOTES: Margins are defined as the ratio of hospitals' aggregate total revenues minus aggregate total costs to aggregate total revenues.

Data are plotted at five-year intervals.

Figure A-5.
Ratio of Average Income of Physicians to Average Earnings of All Workers,
United States and Selected Countries, 1960-1989



SOURCE: Congressional Budget Office calculations based on data from the Organization for Economic Cooperation and Development, Health Data File, 1991.

NOTES: Reliable data on physicians' incomes in Japan are not available

The concepts and estimating methodologies used to compile average earnings per worker are not the same across countries, nor necessarily within each country over time. Among the issues that cannot be taken fully into account are the regional or national basis of the estimates, whether or not both salaried and self-employed professionals are included in the figures, the exact nature of the professional groups covered, the treatment of part-time and female workers, and whether or not the income definitions used reflect income tax, census or national-accounts concepts.

Data for the following years were missing and values were imputed by Congressional Budget Office: 1966, 1968, 1976, and 1980 for the United States; 1962, 1963, 1964, 1966, 1967, 1969, 1970, 1972, 1973, 1975, 1976, 1978, 1979, 1981, 1982, 1984, and 1985 for West Germany. Data missing at the beginning and end of the time period were not imputed.

TABLE A-5. FEDERAL SPENDING ON HEALTH, FISCAL YEARS 1965-1998

	1965	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998
In Billions of Dollars														
Total Federal Spending	118.2	195.6	332.3	590.9	946.3	1,251.7	1,323.0	1,381.9	1,452.9	1,506.8	1,574.5	1,642.8	1,733.0	1,809.1
Federal Health Spending	3.1	13.9	29.5	61.8	108.9	168.0	188.6	222.7	254.2	286.1	320.2	355.5	393.2	434.2
Medicare	n.a.	6.2	12.9	32.1	65.8	98.1	104.5	119.0	134.1	152.3	171.7	192.7	215.3	239.3
Medicaid	0.3	2.7	6.8	14.0	22.7	41.1	52.5	67.8	80.3	91.9	105.0	117.7	131.0	145.9
Veterans Affairs	1.3	1.8	3.7	6.5	9.5	12.1	12.9	14.1	14.9	15.7	16.2	16.7	17.2	18.0
Other	1.5	3.2	6.1	9.2	10.9	16.6	18.7	21.8	24.9	26.2	27.3	28.4	29.7	31.0
As a Percentage of Total Federal Spending														
Federal Health Spending	2.6	7.1	8.9	10.5	11.5	13.4	14.3	16.1	17.5	19.0	20.3	21.6	22.7	23.6
As a Percentage of Federal Spending on Individual Health Programs														
Federal Health Spending	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicare	n.a.	44.6	43.7	51.9	60.4	58.4	55.4	53.4	52.7	53.2	53.6	54.2	54.8	55.1
Medicaid	9.7	19.4	23.1	22.7	20.8	24.5	27.8	30.4	31.6	32.1	32.8	33.1	33.3	33.6
Veterans Affairs	41.9	12.9	12.5	10.5	8.7	7.2	6.8	6.3	5.9	5.5	5.1	4.7	4.4	4.1
Other	48.4	23.0	20.7	14.9	10.0	9.9	9.9	9.8	9.8	9.2	8.5	8.0	7.5	7.1

SOURCE: Congressional Budget Office calculations and projections, January 1993.

NOTES:

Medicare expenditures are shown net of premium income from beneficiaries.

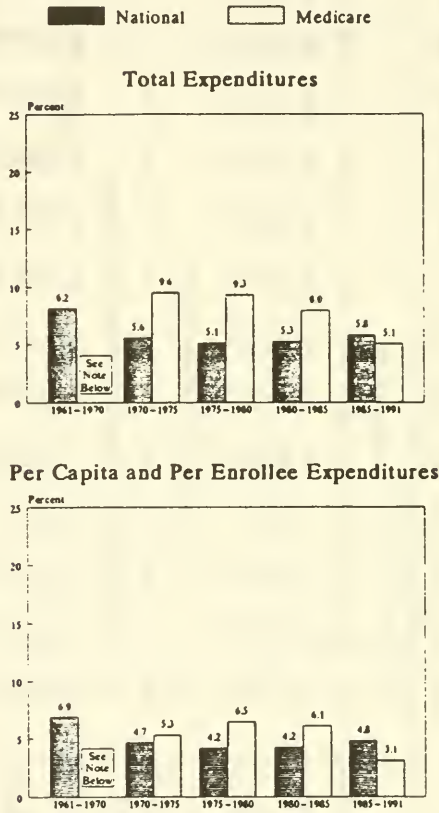
"Other" includes federal employee and annuitant health benefits, as well as other health services and research.

"Federal health spending" excludes spending for the military's CHAMPUS program.

Spending for discretionary programs in the 1993-1998 period is increased each year to reflect projected inflation, starting from the 1993 appropriated levels. Although CBO's projections of total federal spending assume compliance with the discretionary spending limits for the 1993-1995 period, the Budget Enforcement Act does not specify programmatic changes to achieve those limits. Thus, it is not possible to adjust projections for individual programs to reflect the overall limits.

Details may not add to totals because of rounding.

Figure A-6.
Average Annual Growth Rates of Real National and Medicare
Expenditures for Health, Total and Per Capita, 1961-1991



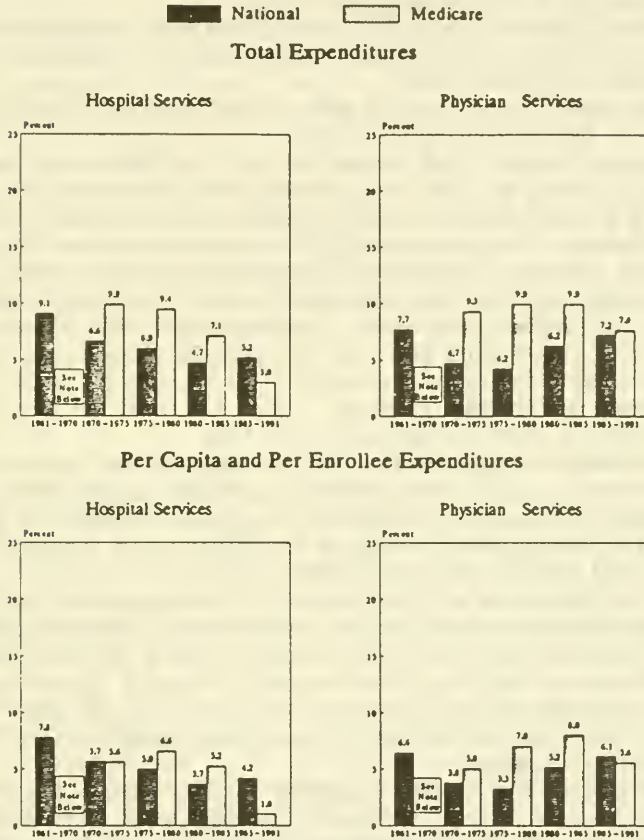
SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Health expenditures are adjusted to 1991 dollars using the consumer price index.

Growth rates are not available for total and per enrollee Medicare expenditures during the 1961-1970 period as the Medicare program was not enacted until the mid-1960s.

Figure A-7.

Average Annual Growth Rates of Real National and Medicare Expenditures for Hospital and Physician Services, Total and Per Capita, 1961-1991



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Health expenditures are adjusted to 1991 dollars using the consumer price index.

Growth rates are not available for total and per enrollee Medicare expenditures during the 1961-1970 period as the Medicare program was not enacted until the mid-1960s.

Chairman STARK. Thank you Dr. Gordon. What I guess I heard you say in your closing remarks is that access and costs are tied together. If costs are going to be up, and if we cut access, costs are going to go down. So we can't affect the balance, is that what you are saying?

Ms. GORDON. I think that is correct.

Chairman STARK. There is no way to expand access to cover the 37 or the 40 million uninsured, without increasing costs on someone; is that your testimony?

Ms. GORDON. If one were to address only access in isolation, it is hard to see how costs would not rise.

Chairman STARK. And if, in fact, all we did was lower costs across the board by, let's say, drastic price controls. By lowering them, we would not affect access unless we took some other action?

Ms. GORDON. That is correct. It is important to realize that the uninsured receive a considerable amount of health care, although substantially less than the insured receive. That care is paid for in part by the higher payments of other payers. So if one were to attack costs by pressing down on the system, those resources would not be available for the uninsured.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Just a continuation on that.

I understand completely the first portion of that, that if you were going to come up with some procedures that reduced the number of the uninsured, then you would have a greater demand on the facilities, and obviously costs would go up. You have a greater universe to cover and provide services to; that follows.

Can you elaborate a little bit more? Because you plug into the second portion of that where you said controlling costs without insurance—health insurance for everyone—you did not say would reduce access to care for the uninsured. You said "probably."

What is the problematic concern that you have on that?

And I think you will agree it is not as automatic as the first portion of the conclusion.

Ms. GORDON. The word "probably" is the result of CBO's fact-checking process. We do not have absolute proof, but we are fairly sure that constraining costs without taking other steps at the same time would limit the funds that are now available to treat the uninsured.

Mr. THOMAS. Depends upon, in part, doesn't it, how we control those costs, the mechanisms that are established? The first is straightforward; that is, you increase the pool, costs go up on the demands because you keep everything else even by themselves, you said. So I think probably on that second statement—not to belabor it, but I think we need to examine the mechanism for cost control, because I think there are some options there that wouldn't necessarily come to that conclusion, as I think you indicate with the "probably."

I have a question in terms of, I guess it is factual or statistical, on page 2 where you indicate that—again, I think self-evident, that most of the time those without insurance who were admitted to hospitals were sicker than those who were insured because the insured, having insurance, tend to do something about it sooner.

But then the next sentence is the one I want you to elaborate on, because you are holding out the poor health aspect, even adjusting for poorer health, you say uninsured patients who are also significantly more apt to die in the hospital.

Do you mean hospitals treat uninsured and insured patients differently, setting aside the degree of sickness when they came?

Ms. GORDON. Yes. This point comes from some research that, as far as we can tell, was done quite carefully. The goal of the analysis was to ascertain whether people who do not have insurance, compared with those who do, receive the same services when they are hospitalized. The answer from this research was no.

The next question the study addressed was, were those services that the uninsured did not receive really of little benefit? Because if they were of little benefit, it would be of little concern that the uninsured did not receive them. Unfortunately, the conclusion was that the outcomes of treatment for the uninsured were considerably worse than the outcomes for the insured, which suggests that the services that the uninsured did not receive would have been beneficial.

Mr. THOMAS. I just find it hard to believe, with the medical liability structure that we have, quality assurance safeguards, followups—

Ms. GORDON. Perhaps I should elaborate a bit. The kind of services I am referring to are not those involved in cases in which it was clear—in which there was no question—that a certain form of treatment should be provided. In those cases, the insured and the uninsured received the same care. But in medical practice, a number of occasions arise on which discretion comes into play—where it is not absolutely clear that one should proceed down a certain path. It was in those areas that the uninsured received fewer services.

Mr. THOMAS. Was there any information in that study that compared those with poorer insurance versus better insurance? That is, is there a linear through the uninsured through the Chevy and Ford plans up to the Cadillac plans? Did structure indicate there was a response in other areas as well to the amount of insurance?

Ms. GORDON. I believe the design of the study was not that detailed. I can check into it and report back to you.

Mr. THOMAS. Thank you very much, Mr. Chairman.

[The information follows:]

A number of studies have attempted to estimate the effect of being uninsured on the use of health services. All of them find that the uninsured use fewer health services. One study estimated that nonelderly adults who were without insurance for a full year were 25 percent less likely than the insured to use any physician services and 54 percent less likely to use inpatient hospital services. Even when some services were used, the uninsured were found to use fewer than the insured: 16 percent fewer physician services and 33 percent fewer hospital services.¹

Although some of the services forgone by the uninsured may be discretionary or of limited value, others appear to be important. A recent study indicated that, among people who were hospitalized, those without insurance were sicker when they were admitted and from 29 percent to 75 percent less likely to undergo each of five medical procedures that are expensive and that have a substantial discretion-

¹ See S. Long and J. Rodgers. "The Effects of Being Uninsured on Health Care Service Use Estimates from the Survey of Income and Program Participation," Bureau of the Census, SIPP Working Paper 9012 (1990).

any element. Uninsured patients were significantly more likely than insured patients to die in the hospital, even after allowing for their poorer health when initially hospitalized and for other factors.²

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Gordon, on your charts, figure 1-A, you indicate that when one considers health care expenditures as a percentage of the gross domestic product, the United States is way above our neighbor, Canada, and much higher than West Germany, Japan, and the United Kingdom. In trying to rationalize the higher expenditures in this country, can one deduce that we have an older population or were unhealthier than the other countries, or are medical advances driving costs?

If you had to pinpoint it, why are we so much higher than the others? What would be your response?

Ms. GORDON. A number of different factors are responsible. Medical technology, for example, is much more available in the United States. Because we have so much of this equipment, some observers believe that we tend to use it—simply because it is available—in circumstances in which it might not be necessary. In addition, we are not very patient; we dislike waiting for diagnostic tests. But rapid access to technology—without waiting—is a very expensive decision that we have made.

Another difference between the U.S. system and that of other nations is that providers, especially physicians, are paid more. In addition, little control is exercised here over a person's choice of providers; whereas in other countries, for example, in Canada, seeing a specialist requires going first to one's primary care physician and then being referred—provided the primary care physician believes it necessary. In the United States, those of us with standard health insurance can decide we need to see a specialist, make an appointment, and go. Our decisions are not questioned.

Mr. KLECZKA. How about hospital stays? Do we have longer hospital stays? Are we trying to fill beds where there might not be a necessity to do so in all cases?

Ms. GORDON. In the case of hospital stays, other countries often have longer stays, but the last few days in those stays are by far the least expensive. As a result, for those countries, longer hospital stays do not necessarily raise their costs a great deal.

Essentially, we have no waiting times in this country—for the reason that you noted. The United States has an excess number of hospital beds. In contrast, in other countries, people frequently have to wait for elective procedures, sometimes for a considerable period of time.

Mr. KLECZKA. Did we overbuild in our hospitals' beds? When a hospital is running 60, 65 percent occupancy, I am assuming someone is paying for those empty beds, because you can't close off full wards in one fell swoop.

Ms. GORDON. We do pay for them—although they are not terribly expensive—if the beds really are empty and segregated from the parts of the hospital that are being used.

² See J. Hadley, E. Steinberg, and J. Feder, "Comparison of Uninsured and Privately Insured Hospital Patients," *Journal of the American Medical Association*, vol. 265, pp. 374-379.

Mr. KLECZKA. You indicate if we are serious about the problem, we must control costs while we take care of the underinsured. If we are to do one without the other, let's say we did nothing with cost controls, but because we felt it was a national embarrassment that 34 million people have no health insurance whatsoever we expand access, what would be the needed dollars to provide basic health care coverage for that group of Americans?

Ms. GORDON. Well, let me see.

Mr. KLECZKA. This would be a guess, I am sure.

Ms. GORDON. If we assume that the uninsured currently receive between one-half and two-thirds of the services of the insured, and that they make up 16 percent of the nonaged population—or about 14 percent of the total population—we would come up with, perhaps, \$50 billion. But we can certainly get back to you with a more precise estimate.

Mr. KLECZKA. If it is 40 to 50, clearly we don't have the dollars for that, so we are going to have to go along with your recommendations and do cost controls while we try to expand access. Thank you very much.

Thank you, Mr. Chairman.

[The information follows:]

HEALTH CARE COVERAGE TO ALL UNINSURED

The answer would differ depending on the kind of coverage provided. Estimates for 1991 (the latest year for which actual figures are available) are given here, using two alternative assumptions about the kind of coverage provided. In each case, the cost of services now used by the uninsured is assumed to be about \$35 billion.

If coverage similar to that available through private insurance policies now in place was provided to those currently without insurance, the total costs for insured services to this group would be about \$60 billion in 1991, assuming that payment rates would be set at the average now paid by private insurers. Benefits paid by insurers would constitute \$48 billion of this amount, and copayments by patients would account for \$12 billion. The net increase in national spending on health would be about \$25 billion in 1991 or about \$33 billion in 1994.

If first-dollar coverage were provided instead, the estimated cost of benefits would be \$74 billion in 1991. Patients would have no copayment costs. National spending on health would increase by about \$39 billion in 1991 or about \$51 billion in 1994.

These estimates make specific assumptions about how much insurance coverage would increase the use of services by people who are currently uninsured. We are reevaluating these assumptions based on more recent data, however; as a result, these estimates may be revised in the near future.

Chairman STARK. Mr. Andrews.

Mr. ANDREWS. One of the things I have been struck by in learning about this health care issue is what little information there is available about how good some of our doctors are, how efficient they are, how efficient hospitals and insurers are. Is that a big part of the problem?

Ms. GORDON. Many analysts have focused on the fact that the United States and other countries have not developed what are called practice guidelines, which would suggest to physicians which treatments are most effective for specific conditions. In part, this is understandable, because medical technology is a moving target because it is changing so rapidly. Nonetheless, various research projects have suggested that a fair amount of the care provided in the U.S. health care system is not particularly beneficial. Those an-

alysts conclude that practice guidelines would help reduce expenditures without adversely affecting health outcomes.

Mr. ANDREWS. For instance, Mr. Kleczka mentioned hospitals that have 60-some-odd percent occupancy. Six months ago we made an inquiry about hospitals—who is good and who is bad—and one of the solid pieces of evidence was how many people die in a hospital, which I don't think necessarily distinguishes what is a good hospital from a bad one all the time, especially if it is a hospital like the M.D. Anderson Cancer Research Center in Houston. I guess to try to get a handle on who is good in the system, it just seems to me a part of reform has to be a better outcomes analysis.

I am not so sure that a hospital that has 60 percent occupancy makes it necessarily inefficient, depending on the region it is in, where it is located, what kind of patients it treats. But don't we have to get a better handle on who is good and who is bad and who does a good job—in doctors, for instance, who uses treatment instead of immediately going to surgery, or what doctor uses an MRI machine on every occasion as opposed to something that is far less expensive? Is that a part of the problem?

Ms. GORDON. Many of the proposals for modifying the health care system include as a component the development of a national data base for comparing how patients with the same condition are treated. The data base would allow comparisons among physicians, hospitals, and regions, with an eye to discerning how treatment might be improved. Saving money is not necessarily the end result, though, because in some cases you may find that expenditures must be increased to bring the treatment up to the standard identified as desirable. In other circumstances, this kind of information might lead to savings.

Mr. ANDREWS. It would, as a component, give consumers much more information about who is a cost-effective doctor and where they could get the least expensive treatment.

Ms. GORDON. This kind of information is extremely difficult to obtain. Consumers could certainly benefit from more information. And most physicians would argue that they need more information as well. But the research needed to determine the effectiveness of alternative patterns of treatment for a given condition is not available in a great many cases.

As a result, the idea of trying to identify high-quality providers is certainly appealing, but some very difficult technical questions would have to be resolved in order to do that.

Mr. ANDREWS. Can it be done?

Ms. GORDON. Progress is possible, but it is not a trivial task. People may have the same medical condition and yet have all sorts of different characteristics. These varying factors make it difficult to compare patterns of treatment and conclude which ones are best. This is why clinical studies tend to be so expensive and why they often have a relatively small number of participants, which then presents problems in trying to draw major conclusions from them.

Mr. ANDREWS. It does seem kind of ridiculous sometimes that we know so little about our doctors and our providers.

Ms. GORDON. I certainly think we could know much more than we know today.

Mr. ANDREWS. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Thank you for your testimony. Has CBO looked at all at some of the new things that are hanging out there in the private sector that apply the total quality management approach to the provision of health care services? My impression is that these efforts are rather young, but are making some quite remarkable changes; and I just wondered to what extent—it kind of goes along with my colleague from Texas who is questioning about guidelines and their impact on savings. We don't know a lot about it, but we have reason to believe it is going to be very significant.

In management changes, my impression is we don't know a lot about it. I wonder if you know a lot about it.

Ms. GORDON. I wish we did. We do everything we can to stay abreast of the research being done around the country, but this is not an area in which the CBO staff would be conducting research itself. We do have experts—who I must say are extremely helpful—who come in and brief us on their findings, often before they appear in the published literature.

Mrs. JOHNSON. I am hoping that this committee will hold a hearing on that subject, because my experience in other sectors of the economy is that a great deal more has been saved by changing the way business is done, rather than by cutting budgets. If you watch other bills in the service sector or the manufacturing sector, cuts made over years didn't produce nearly the savings nor the increase in quality and productivity that changes in the way in which services were delivered did; and I think it is an area in which we need more knowledge if we are going to make great decisions about cost control.

Thank you.

Mr. LEVIN. Mr. Lewis.

Mr. LEWIS. Dr. Gordon, do you have any information or research data that would show the impact of the use of tobacco or violent crimes on the cost of health care in America?

Ms. GORDON. No, I am afraid I do not have information about the effects on health status of the use of tobacco.

Mr. LEWIS. What about violent crimes? Is the American society much more violent than, say, the Canadian, West German, Japanese or British?

Ms. GORDON. One could conclude, perhaps, that U.S. society is considerably more violent than Canadian society, but again, it is not something that we have analyzed.

Mr. LEWIS. Thank you.

[Additional information follows:]

Q. Mr. Lewis: Do you have any information or research data that would show the impact of the use of tobacco or violent crimes on the costs of health care in America?

A. Smokers use more medical care at all ages than people who have never smoked, but "never-smokers" live longer and use medical care over a greater number of years. Research findings published in the 1980s, based on data from Switzerland, suggested that total lifetime expenditures for medical care for never-smokers were greater than for smokers. More recent research conducted in this country, however, found that the effects on costs of smokers' greater use of medical care while alive outweighed the effects of their shorter life expectancies. The following results are from that study.

The researchers estimated that the population of smokers aged 25 and older incurs about \$160 billion in excess medical expenses every five years. In addition, they projected that the population of smokers aged 25 and older in 1985 would incur excess medical expenditures of about \$440 billion (in 1990 dollars) over their remaining lifetimes, using an inflation-adjusted discount rate of 3 percent. The researchers assumed that 87 percent of the difference in expenditures between smokers and never-smokers would remain after controlling for such confounding factors as alcohol consumption and other lifestyle differences, income, and education. (That assumption was derived from other published research.) An important caveat about these findings is that the researchers took no account of the effects of quitting smoking. They are hoping to conduct further research on the effects of quitting on the lifetime medical expenses of smokers.

Less information exists about the health care costs associated with violent crime because it is difficult to distinguish between intentional and unintentional injuries in studies of their costs.

Nonetheless, although one cannot generalize from a single geographic area to the entire nation, statistics from hospitals located in the District of Columbia illustrate the high medical care costs associated with violence and the associated financial burdens imposed on hospitals that treat trauma victims. We are including a copy of a 1991 letter from Dr. Howard Champion of the Washington Hospital Center to the Committee on the District of Columbia. Dr. Champion cites a study that estimated that, in 1989, the total health care costs (including physician and rehabilitation care) associated with criminal violence in the District were more than \$40 million. He also provides 1990 statistics from the Washington Hospital Center. In that year, the center treated almost 700 patients with gunshot and stab wounds at a total cost of about \$8 million (not including physician fees or outpatient and rehabilitation costs). Forty-two percent of those patients were uninsured. An additional 34 percent had some form of government coverage, but the coverage paid only 38 percent of their costs.

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Howard R. Champion, F.R.C.S. (Edin.), F.A.C.S.
Director, Professor of Surgery

The Honorable Ronald V. Dellums
Chairman, Committee on the District of Columbia
1310 Longworth House Office Building
Washington, D.C. 20515-6070

November 20, 1991

Dear Mr. Chairman:

I recently became aware that the Committee on the District of Columbia will be holding a hearing on November 21st on H.R. 3712, a bill to repeal the "Assault Manufacturers Strict Liability Act of 1990."

This legislation, the result of a voter referendum, is an attempt by the people of the District of Columbia to gain some measure of control over the escalating violence in the District. I would like to bring to the Committee's attention that this horrific violence is not only reprehensible in terms of the cost in destroyed human lives, but also in its impact on the District's system of health care.

I would like to submit for the record a study sponsored by the District of Columbia Hospital Association assessing the health care costs of criminal violence in the District. Researchers found that hospital costs for D.C. residents were \$20.4 million in 1989, with total health care costs, including physician and rehabilitation care, estimated to exceed \$40 million. Fifty-five percent of these costs were due to crimes involving a firearm; 68 percent of the victims of violent crimes were uninsured and these victims account for 10 percent of all uncompensated care in District hospitals in 1989.

A study of gunshot wound admissions to the Washington Hospital Center, caused by assault, rose from 9.6 admissions per month from 1983-1986 to 43 admissions per month in January, 1989 and then leveled off at 30.2 admissions per month for the remainder of 1989 through 1990. The average number of entrance wounds per patient rose correspondingly from 1.5 prior to 1987 to 2.2 during 1988-1990. The number of patients with multiple entrance wounds increased from 28 percent to 44 percent, and patients with five or more entrance wounds grew from 1.8 percent to 8.1 percent. Not surprisingly, the Washington Hospital Center's consistently declining death rate for gunshot wound patients was reversed in 1988 and began to climb.

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Chairman, Ronald V. Dellums -- page two

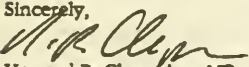
Related hospital costs rose rapidly with these gunshot wound patients accounting for an average increase in costs for the Washington Hospital Center of \$4 million per year. Unfortunately, because most gunshot wound patients are young unemployed males involved in the illegal drug trade, they are uncovered by insurance or Medicaid. Fully 37 percent of gunshot wound patients were found to be uninsured. Another 35 percent were covered by government programs that reimbursed only 38 percent of the cost of care. Altogether, the increase in hospital costs arising solely from the increase in gunshot wound patients resulted in an average annual loss of more than \$2 million in unreimbursed costs for the Washington Hospital Center.

A separate review of hospital costs for total gunshot wound patients and stab wound patients admitted to the Washington Hospital Center during 1990, found that hospital costs for treating 395 gunshot wound patients and 283 stab wound patients totalled \$7.93 million. Fully 42 percent were uninsured resulting in a loss of nearly \$2 million. An additional thirty-four percent were "covered" by government programs (e.g., D.C. Medicaid) which reimbursed for 38 percent of costs for a net loss of \$2.5 million. These figures represent initial hospital admission costs only and do not include physician fees, or outpatient and rehabilitation costs.

Trauma patients must receive definitive care in the shortest time possible to survive or prevent disability. Because D.C. General Hospital, the Washington Hospital Center, and Howard University Hospital are in, or near, violence prone areas they receive a disproportionate share of the uninsured injured. Two of these trauma centers are private hospitals and receive no public subsidy to operate their trauma service. The escalating violence in the District of Columbia has so seriously stressed the financial capabilities of the Washington Hospital Center that administrators have publicly warned MedSTAR, regarded as one of the nation's finest trauma centers, will have to close its doors. This would be a tragedy, not only for those caught up in drug-related violence, but also for police officers wounded in the course of duty, for innocent by-standers, and for those severely injured in motor vehicle crashes or falls which still constitute the largest number of admissions to the trauma center.

I sincerely hope the Committee will seek to address the financial stress facing several of the District of Columbia's trauma centers who have been the forgotten element in the District's war on drugs. The war cannot be won without the back up of the trauma centers that, in many cases, function like the MASH units in the Korean, Viet Nam, and Persian Gulf wars.

Sincerely,


Howard R. Champion, MD

Mr. LEVIN [presiding]. Mr. McCrery.

Mr. MCCRERY. Thank you.

Dr. Gordon, I have served on the Budget Committee for the last 5 years and I have looked at the budget, nine ways to Sunday, trying to figure out a way to get out of this deficit situation that we are in annually. And it does appear that Medicare and Medicaid pose perhaps the biggest problem in terms of the out-year expenditures and the growth of those programs. They are growing much faster than any other component of the budget.

But tell us, if you will, if you can, how much are Medicare revenues growing in the out-years? In other words, is the—are the Medicare taxes, so to speak, going to begin to pay for Medicare part A, and are premiums going to—for part B, for the foreseeable future—going to continue to provide about 25 percent of the costs of part B?

Ms. GORDON. To take part A first, payroll tax revenues increase with wages and salaries, which are rising considerably more slowly than health care costs. So payroll tax revenues are not keeping pace with the growth in these costs.

In regard to part B, a sequence of legislative acts have extended the requirement that premiums cover 25 percent of the program, and that requirement may continue in the future. But what that means is that those premiums will rise more rapidly than people's incomes. The other 75 percent of part B, which is funded by general tax revenues, will again be growing very rapidly, as you observed.

Mr. MCCRERY. At what point will part A cease to pay for itself?

Ms. GORDON. The projections I am familiar with involve the Medicare trust funds, which have a positive balance. Those figures do not really provide the answer to your question.

Mr. MCCRERY. That is what I am looking for.

Ms. GORDON. I think the projections point to difficulties at the beginning of the next century.

Mr. MCCRERY. Yes, the first few years of the next century, like the first 5 years, maybe, of the next century.

Ms. GORDON. I believe so.

Mr. MCCRERY. So at that point, general revenues will begin to subsidize Medicare part A, as they do now part B.

Ms. GORDON. That is a decision that the Congress is going to have to make—there is no automatic response. The trust fund will not have enough money to pay the program's bills, but I expect that before the situation gets to that point, legislation will be enacted to deal with either expenditures or inflows into the trust funds.

Mr. MCCRERY. Right.

All right, let's move on to the question of controlling costs. Given that Medicare and Medicaid constitute a substantial burden on the budget and particularly in terms of trying to balance the budget, to what extent will reducing the increase or the rate of increase in the general underlying health care costs in our society affect Medicare and Medicaid expenditures in the future.

Ms. GORDON. The major driving force behind these projections of rapid increases in expenditures for Medicare and Medicaid is the rapid rise in health care spending in general. In fact, in compari-

son with other payers, Medicare has been able to control costs more effectively, and consequently its costs are considerably lower.

To deal with the Federal budget problem, however, I think that you have identified exactly the right issue: we must control national health expenditures, which are really what is driving Medicare costs now.

Mr. McCRERY. At some point I would like to go into this further. I mean, I think—my gut tells me you are right, but my mind is having trouble reconciling what you have just said with you earlier statement regarding Medicare payments to hospitals.

Ms. GORDON. Medicare has been addressing its own reimbursement rates quite directly: it pays hospitals and physicians less than they are paid by private payers. The problem is our multipayer system. Medicare's lower rates affect other payers, who end up with higher expenditures. As a result, total expenditures do not seem to be slowing by very much.

Mr. McCRERY. So my point is, if we are controlling Medicare and Medicaid costs arbitrarily with governmentally imposed mechanisms, then how is bringing down the underlying health care costs generally going to affect those Medicare and Medicaid costs that are already being controlled with mechanisms?

Ms. GORDON. The answer lies in the cost control policies being considered. Depending on how those policies tackle the overall cost problems, some spillover benefits could potentially help reduce Medicare and Medicaid costs. But if the policy that was used was, for example, an all-payer system that applied Medicare's rates to all other payers, then—for that particular example—Medicare would pay the same.

Mr. McCRERY. Thank you.

Chairman STARK [presiding]. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman. Just a brief point on this matter. Your last chart really doesn't have any new information, but it is still striking; and that is, when you look at the growth rate of hospital services and physician services from 1985 to 1991, especially in Medicare, there is a dramatic difference, isn't there?

Ms. GORDON. Yes, it is quite striking.

Mr. LEVIN. And I take it, in substantial measure that reflects the institution of the DRG system for hospital services, while there wasn't a similar ceiling on reimbursement for physician services.

Ms. GORDON. That is correct. In addition, compared with physicians, it is much more difficult for hospitals to increase the volume of service that they provide.

Mr. LEVIN. So while the cost containment is indeed a difficult, if not treacherous, area, I would think from these figures we should not assume is that we are helpless to try to get ahold of costs.

Ms. GORDON. It is not a question of being helpless. Rather, cost control requires changes that also have undesirable effects. Analysts have been saying for a number of years that the methods are available to control costs. For example, prohibiting first-dollar coverage for insurance, limiting payment rates, uniformly monitoring providers to control the volume of services that they provide, limiting the acquisition of new technology, perhaps also adding some kind of global cap on total expenditures—most people agree that these kinds of things in combination would control costs. Perhaps

the way to put it is that there is no free lunch. Instituting these policies would force us to give up some of those strengths of our health care system to which we seem quite attached.

Mr. LEVIN. I am not sure that the four or five items that you have mentioned would necessarily require us to give up the strengths. I agree there is no free lunch, but you talked about caps, you talked about utilization review, you talked about some limits on technology. I think that may spill over into issues of strength.

What was the first one you mentioned?

Ms. GORDON. Not permitting insurance to cover the first, beginning dollars of health care spending.

Mr. LEVIN. Right. Larger copays, et cetera, and broader participation. I am not sure that all of those necessarily would impinge on the strengths that we have in our system. They may not be popular, but that doesn't mean they would erode the strengths of the system, right?

Ms. GORDON. The key is the extent of the erosion—what level is considered a difficulty. Controlling the acquisition of new technology would probably increase waiting times. But by how much? The answer would depend on how strict those controls were. In addition, people would disagree about whether an increase in waiting time was a problem.

Mr. LEVIN. Just one last quick question. All of the other industrial nations—whether they have a single-payer like Germany or a more diversified system—all of them have the kinds of—the kinds of, if you wanted to call it, “regulation” or “caps” or provisions that you have mentioned.

Ms. GORDON. Among other industrialized nations, the more common approach is to determine what proportion of the gross domestic product should be spent on health care and to start the policy process from there. It is not a uniform approach by any means, but it is much more common.

Mr. LEVIN. Thank you.

Chairman STARK. The Chair would like to acknowledge that one of our new colleagues, Mr. Grandy of Iowa, is with us. We welcome him to the subcommittee.

Fred, good to have you. Would you like to either inquire or address?

Mr. GRANDY. I would like to inquire, Mr. Chairman. I would like to ask a couple of questions.

I was trying to review your testimony as quickly as I could, Ms. Gordon, about the statistics relating to the insured population versus the uninsured population. If you take that 15.9 percent—and that is the uninsured population, that 34.2 million people—

Ms. GORDON. Correct.

Mr. GRANDY [continuing]. That is the CBO figure on that. Do you break that figure down any further, temporarily uninsured, and if so, for how long, voluntarily uninsured or structurally uninsured people who are in the workplace and aren't going to get a policy any time soon, absent some major rewrite?

I guess I am trying to get a bead on the difference between the number and the population that really may be at risk, the people that ostensibly we are trying to help with whatever design we can come up with.

Ms. GORDON. The data in the testimony come from the Current Population Survey, which is conducted by the Census Bureau. The survey looks at people who lack health insurance at a particular point in time. In this case, the survey was done in March 1992.

Other sources of data can also shed some light on the questions you are asking. For example, in 1988, the Census Bureau conducted a special survey that considered insurance status in more detail. One focus of the study was people who were working and had been offered health insurance but who in fact lacked coverage. Several questions arose. Is this a voluntary decision? That is, are people choosing not to have health insurance? If they are, is the lack of coverage still a pressing concern? The size of the population of people in this situation is a factor. To determine that, you must first eliminate the people who have turned down health insurance from their own employer because they have coverage from, for example, a spouse's policy; the people who work part time and are not eligible for health insurance; and the people who have just started to work for the firm and are not yet eligible for health insurance. After subtracting these groups, you can see that about 5 percent of employees are voluntarily choosing not to take the health insurance coverage that is available from their firm.

Mr. GRANDY. And implicit in what you are saying, then, there is a population that is between policies. Their COBRA has expired and they don't have another job, or they are in the workplace, they had no COBRA to begin with.

Ms. GORDON. Or perhaps they were never attached to the work force at all. Table A-2, in the testimony, I think, is the most useful for your question, Mr. Grandy.

Mr. GRANDY. OK, thank you.

Ms. GORDON. If you are interested in the work force connection—I am sorry, I sent you to table A-2, but I should have sent you to table A-3, which looks at the extent to which people are attached to the work force. The bottom panel of the table shows the percentages of people who are uninsured and who are full-time workers or dependents of full-time workers, which total just over 50 percent. The table also shows part-time workers, dependents of part-time workers, and those with no connection to the work force.

Mr. GRANDY. And has that figure remained constant or has it increased? I mean, since I have been involved in this debate, it has been roughly 15 percent of the population. That spans about a 5-year period. Has it remained that?

Ms. GORDON. It is a little higher now because of the recession.

Mr. GRANDY. I understand that, but that notwithstanding—

Ms. GORDON. The trend in the portion of the population that is uninsured has been rising slowly over time.

Mr. GRANDY. That begs the other question. That is a little harder to figure out demographically. If you go back and look at the other part of the pie, the insured population, is there any data that indicates what number of that bunch is overinsured, that has more benefits than they need, either because they negotiated a generous union plan or they are a Federal employee or they have a package that perhaps, because it is subsidized by the Tax Code, is more than they really need, and were there a basic benefit scheme some-

where in the greater cosmos of health care, a lot of those benefits would not be included, certainly not forgiven by the Tax Code.

Ms. GORDON. Certainly some policies are exceedingly generous. But if insurance policies are considered in terms of their actuarial value, which gives a sense of how rich the benefit package is, the distribution is really quite tight. In other words, the differences in, say, the middle 80 or 90 percent of the policies are really quite small. A tail extends in both directions, however, with some policies providing relatively few benefits and some providing extremely generous packages.

Perhaps I should qualify this statement: these results are based on policies of some large firms. Nevertheless, the dispersion was not as great as had been expected.

Mr. GRANDY. Do you happen to have a figure as to what the average benefit is worth in the workplace of the insured population? Is there a quantifying number, \$3,500, \$4,000, something like that, per employee?

Ms. GORDON. I do not have such a figure here, but I can provide some specific information later.

Mr. GRANDY. I would like to see what the average policy is that is being basically underwritten under the code. Thank you, Mr. Chairman.

[The information follows:]

In 1991, the average actual premium for health insurance per covered employee was \$1,440 for single coverage and \$3,690 for family coverage. On an actuarial basis—that is, adjusted for differences in risk—the premium per covered employee in 1991 for a plan at the median level of benefit generosity was about \$1,350 for single coverage and \$3,230 for family coverage. At the median, insurance packages are comprehensive and have deductible amounts of \$50 for individuals and \$250 for families, coinsurance rates of 20 percent, and limits on out-of-pocket expenses of roughly \$500 per person. The cost of insurance coverage for workers in any given firm, however, depends on the generosity of the benefit package, the number of workers employed by the firm, and the characteristics of the firm's employees.

Chairman STARK. If there are no other members who would like to inquire further, I want to thank Dr. Gordon and her staff. We look forward to working with you in this Congress, and I suspect with everything that is on our plate, we will be seeing a good bit of you. Thank you very much.

We will continue with testimony from two commissions which advise the Congress on health care payment policy. On this panel we have Dr. Bruce Vladeck, the acting chairman of the Prospective Payment Assessment Commission, affectionately known as ProPAC, that advises on the hospital reimbursement, accompanied by Dr. Don Young, the executive director; and our friend, Dr. Philip Lee from the great State of California, chairman of the Physician Payment Review Commission, affectionately known as PPRC. He is accompanied by Dr. Paul Ginsburg, the executive director.

Welcome, again, gentlemen, to the committee.

We will first hear from Dr. Vladeck. Your prepared testimony will appear in the record, so why don't you enlighten us however you're comfortable.

STATEMENT OF BRUCE C. VLADECK, ACTING CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. VLADECK. Thank you very much, Mr. Chairman, members of the committee. It is always a pleasure to be here, although I think this may be my first appearance representing the commission, which gives me the opportunity to make it clear how much all of us commissioners rely on the staff and particularly Dr. Young to do the work for us.

In accordance with your suggestions, let me ask you, if I might, to turn to the charts that are in the back of our prepared testimony and just very quickly talk about some of the points contained in those charts. There are really three issues I would like to touch on before you this morning, each very briefly.

First, I want to talk a little bit about where cost increases come from, what it is that is, in fact, driving this extraordinary growth in health care costs. We would be irresponsible as representatives of the commission if we didn't say a word or two about the Medicare experience over the last decade relative to costs, and then we have a little bit of data suggesting what happens when you control one part of the system and not others. And I think that is the third point I want to make.

If I could very quickly call your attention to chart 2 at the back of our testimony. Chart 1, again, largely recapitulates data that CBO provided you with. You see that one of the things that has confounded us in terms of controlling health care costs is that there are really two components. The basic principle of economics is that total expenditures equals price times volume, and this deals with the problem of health care costs.

You have two sets of issues, one is price and one is volume. We have estimated at ProPAC, that about 85 percent of the increment in hospital expenditures over the last 5 years or so has been a result of price increases and only 15 percent the result of volume increases.

Our colleagues at the Physician Payment Commission have a more difficult task in a sense because both price and volume have contributed roughly equally to expenditure increases, and you can look on the data on other services as well.

Chart 3 looks at what has happened to total hospital inpatient utilization over the last decade. I should point out that in the last 3 or 4 years, the Medicare trend, which had been parallel to that of the national trend, has turned around a little bit and Medicare admissions are up somewhat over the last several years, although that is largely a result of the fact that the eligible population is growing and aging, so that Medicare admissions per enrollee continue to be flat or on a downward decline. But for the nonelderly population admissions are not increasing—again the point is we are spending more on hospital services while receiving less in the way of inpatient services.

And I would also add that the 15 percent from the previous chart that shows a volume increase in contributing to the growth in hospital expenditures is attributable entirely to outpatient services, which have grown very rapidly.

Chart 4 is quite complex. And it is Dr. Young's favorite product so we had to include it. But it is important. I don't want to spend too much time. I would be happy to answer questions. But basically it shows what happens if you decompose the components of the growth in hospital costs and you pull out inflation in the economy as a whole and you pull out the fact that patients are getting sicker on average and you pull out some of the costs of new science and new technology.

Even then, costs are going up. There are at least three reasons for that. One is in an unconstrained health care economy, the price of what health care providers purchase consistently goes up faster than other consumer prices. We have seen that most markedly in labor costs over the last decade, whereas you all know, real incomes for most workers in the United States declined in the 1980s. They went up about 5 percent for health care workers, but it is just as true of supplies and consumables and other things that hospitals purchase.

Our last three columns really suggest a chronic longstanding productivity problem in the hospital industry, and I would suggest the hospital industry, in fact, has done much better because of the concentration of size and the application of scale to management than other parts of the health care sector in some of the issues that Mrs. Johnson was talking about earlier in terms of doing better with less as other industries in the United States have done.

Very quickly, charts 5 and 6 demonstrate the extent to which over the last half dozen years we have reversed the pattern. Medicare growth was leading national health care cost growth prior to that time. Since then, largely as a result of legislation written in this subcommittee, it has lagged behind growth in the risk of the sector.

But we have a problem and the problem is that Medicare patients and indeed Medicaid patients receive their health care from the same providers in the same health care marketplace from nurses who are in the same marketplace, use drugs that are sold in the same marketplace as those that are in the nonpublicly subsidized sector. And, therefore, you get the kind of phenomenon you see in chart 8 which shows that every time Medicare saves money by reducing its payment rates, hospitals and other providers are able to maintain their revenues by increasing the prices they charge to everyone else.

That not only creates the phenomenon we know as cost shifting, but also a kind of vicious spiral because, in order to continue to maintain access for Medicare and Medicaid patients to the mainstream health care system, we have to play catchup with the prices the private sector is paying. We have to recognize that institutions that serve predominantly low-income people have to meet standards of care comparable to institutions that serve primarily privately insured people.

The price of labor goes up in the whole labor market, not just in the privately insured labor market. The price of equipment is dominated by the privately insured market. There aren't separate MRIs for Medicare patients and non-Medicare patients. So an inability to get a handle on the whole problem continues a spiral that not only affects the cost of the privately insured but, over the

long term, we believe makes it harder to keep Medicare costs down as well.

I have been very brief as requested, but I would be happy to respond to any questions now or at a further point.

Chairman STARK. Thank you very much.

[The prepared statement and attachments follow:]

**STATEMENT OF BRUCE C. VLADECK, PH.D., ACTING CHAIRMAN,
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION**

Good morning Mr. Chairman. I am Bruce Vladeck, acting Chairman of the Prospective Payment Assessment Commission, an independent Congressional agency created to analyze and make recommendations on Medicare payment policies for hospitals and other facilities. With me today is Donald A. Young, M.D., the Commission's Executive Director. During my testimony, Mr. Chairman, I will refer to several charts. These charts are appended to the end of my written testimony.

HEALTH CARE SPENDING

I am pleased to appear this morning to discuss the trends in health care costs and payments. The numbers are sobering, Mr. Chairman. Despite increasing attention to controlling costs, national expenditures for health care increased over 250 percent between 1980 and 1990, from \$250 billion to \$675 billion. If this current trend continues, annual expenditures will reach \$1.7 trillion by the year 2000. The rate of growth in health care expenditures has far exceeded the growth in our Gross Domestic Product (GDP) and, as a result, health care spending as a percent of our national income has grown from 9.2 to 12.1 percent in the last decade and is projected to rise to 18 percent of the GDP by the year 2000.

There are four major factors fueling the growth in health care spending: population growth, economywide price inflation, medical price inflation and the intensity of services furnished to each patient. Medical price inflation is specific to the health care industry and may result from higher wages in the health care industry, poorer productivity, and health care pricing strategies. Intensity measures changes in medical practice patterns and technology. Between 1990 and 1991, population growth and economywide inflation accounted for about 45 percent of spending growth, while medical price inflation and service intensity accounted for the remaining 55 percent.

HEALTH CARE SERVICES SPENDING

A closer examination of national health expenditures reveals the variation in spending among various health care services (see Chart 1). As Chart 1 indicates, while hospital care remains the largest source of spending, ProPAC estimates that its rate of increase will slow through 1995, from an average annual increase of 13.7 percent to 11.5 percent. In contrast, the rate of increase in spending for physician services is projected to continue to rise over this same time period, from 9.9 percent to 10.5 percent.

Health care spending can increase because the price of services increases or because the volume of services increases. As you can see in Chart 2, the relative contribution of price and volume differs substantially by service type. In recent years, most of the growth in hospital spending was due to price increases, while over half of the growth in physician services was due to the volume of services provided. Similarly, for nursing home care, price was a major determinant of spending while volume was the major reason for spending growth in the home health care industry (see Chart 2).

The 15 percent volume share of spending growth of overall hospital services depicted in Chart 2 was due to the rapid growth in outpatient services in recent years. The amount of inpatient hospital care has actually declined recently, as indicated by the decline in patient admissions (see Chart 3). Over the last decade, the number of inpatient hospital admissions fell 13 percent. Excess hospital capacity continues to be a major problem, however, because the reduction in bed capacity did not keep pace with declining admissions. As a result, community hospital occupancy declined from 76 percent in 1981 to 64 percent in 1991.

FACTORS RESPONSIBLE FOR INCREASING COSTS OF HOSPITAL SERVICES

Traditionally, spending for health care is linked to the costs of producing that care. At the hospital level, operating costs per admission grew at an average rate of

8.9 percent per year between 1985 and 1990 -- more than double the rate of general inflation. The major factors responsible for this growth in hospital operating expenses can be grouped into three broad categories: increases in inflation, increases in the amount of services furnished to patients, and changes in the hospital inputs used to furnish patient services (see Chart 4). Let me explain each of these categories in a bit more detail.

Inflation

The largest single contributor to the growth in the cost of hospital care between 1985 and 1990 was inflation in the general economy, as measured by the Consumer Price Index. Economywide inflation accounted for 3.5 percentage points, or about 40 percent, of the average cost increase from 1985 to 1990. Inflation specific to the hospital industry accounted for an additional 1.5 percentage points, or about 17 percent, of the annual increase in hospital expenses. Hospital inflation includes hospital employee wage increases, which were rising faster than wage rates in the general economy during that time. The increase in the price of hospital labor was partly in response to an increased demand for registered nurses and other personnel.

Patient Care

Hospital expenses escalate as patients with more complex conditions are treated. In recent years, the complexity of patients treated in hospitals has increased significantly. This trend is due, in part, to increasing treatment of less severely ill patients in outpatient settings. Based on ProPAC estimates, real increases in case mix and patient complexity accounted for 1.9 percentage points, or about 21 percent of the annual increase in costs per admission.

In addition to treating more severely ill patients, hospitals have increased the intensity of the services they furnish to each patient. Changes in intensity accounted for an estimated 1.8 percentage points, or 20 percent of the annual increase in hospital costs per case. ProPAC has estimated that about one-third of the annual cost increase from intensity was due to advances in technology while two-thirds of the increase was due to a greater use of established tests and procedures.

Hospital Inputs

A hospital's expenses are also affected by the mix of labor and other goods it uses to furnish patient care. This mix is referred to as hospital "inputs." Increases in labor and non-labor inputs are estimated to have contributed 0.8 percent, or about 9 percentage points, to the increase in hospital costs between 1985 and 1990. Hospitals have significant flexibility in determining the amount and mix of inputs, both labor and non-labor, used to provide services. For example, during the 1980s, hospitals increased their labor skill mix by employing more registered nurses and fewer licensed practical nurses.

HEALTH CARE PAYERS

While overall costs and expenditures are useful numbers, Mr. Chairman, they do not tell the full story. There is tremendous variation in levels of payments among the various payers for health care services, such as the Medicare program, state Medicaid programs, and private payers. Such variation allows providers to obtain additional revenue from some payers to offset losses from other payers. This is commonly referred to as "cost shifting." As a result of this ability to cost shift, health care costs continue to increase despite efforts that control payments.

The Medicare program's prospective payment system (PPS) is a good illustration of the cost-shifting phenomenon. Medicare program expenditures constitute more than one-third of all health care spending. As the largest single payer for health services, Medicare policies have a strong impact on the health care system. During the 1980s, the Medicare program dramatically changed the way it pays for

hospital and physician services in an attempt to control Medicare program expenditures and create incentives for providers to increase their efficiency in providing services. Rather than reimbursing hospitals for their actual costs incurred, as was the case during Medicare's first 16 years, Medicare now uses a prospective payment system to pay hospitals for the costs of treatment.

The Medicare prospective payment system has been very effective in controlling federal health care spending (see Chart 5). During the 1970s, prior to the implementation of PPS, Medicare expenditures per enrollee were growing faster than national expenditures per capita. Since the implementation of PPS, the rate of spending has slowed such that by the end of the 1980s, the rate of Medicare spending growth was below that of national spending.

The decline in the spending growth of hospital inpatient services was the major reason for the overall Medicare spending slowdown (see Chart 6). In the six years prior to PPS, hospital inpatient payments were growing at a real annual rate -- that is, adjusted for general inflation -- of 9.1 percent. Over the first six years of PPS, this rate fell to 2.5 percent. In contrast, Medicare spending for other services, such as outpatient, rehabilitation, and ambulatory care -- where spending generally is not determined prospectively -- has continued to accelerate.

Despite Medicare's financial pressure on hospitals to control their costs, hospital costs have continued to grow rapidly. Since the first year of PPS, Medicare operating costs per hospital discharge have increased at an annual rate of 9.4 percent, almost 80 percent faster than Medicare payments (see Chart 7).

The problem, Mr. Chairman, is that while Medicare is a major player in hospital reimbursement, it is not the only player. Rather than reducing costs as Medicare payments were limited, hospitals obtained additional revenue from other sources to maintain their financial position (see Chart 8). In fact, in recent years, the total operating margins for hospitals -- that is, net revenues minus costs -- have actually been increasing (see Chart 9).

Much of hospitals' additional revenue comes from charging privately insured patients more than the cost of their care. Consequently, the Medicare program is now paying less than the cost of treating Medicare patients while private payers are paying more. As Chart 8 indicates, in 1990 private insurers paid hospitals 28 percent (\$22.5 billion) more than the costs of treating their patients. With much of the private insurance market unconstrained, the Medicare program does not provide adequate leverage to hold down the increase in overall hospital costs. The lesson from the Medicare experience, Mr. Chairman, is that to be truly effective, cost control efforts must be comprehensive.

SUMMARY

Mr. Chairman, the information I have presented today illustrates the severity of the health care crisis confronting this country. Health care costs are increasing at a rate that is clearly unsustainable in the long run. The need to defuse this time-bomb cannot be overstated.

I would be pleased to answer any questions you or other members of the subcommittee may have.

Chart 1

Change in Projected National Health Expenditures for Selected Services, 1991-1995

	Expenditures (In Billions)			Average Annual Percent Change	
	1990	1991	1995	1990-1991	1991-1995
National health expenditures	\$675	\$752	\$1,124	11.3%	10.6%
Hospital care	258	289	447	13.7	11.5
Physician services	129	142	212	9.9	10.5
Dental services	34	37	47	5.5	6.1
Other professional services	31	36	55	12.0	11.4
Nursing home care	53	60	94	11.5	11.8
Home health care	8	10	19	21.5	17.8

SOURCE: ProPAC estimates based on unpublished HCFA data.

Chart 2

Price and Volume Composition of Growth in Selected National Health Expenditures

Type of Expenditure	Estimated Share of Increase*	
	Price	Volume
Hospital care	85%	15%
Physician services	48	52
Dental services	94	6
Other professional services	44	56
Nursing home care	68	32
Home health care	21	79

* Estimates reflect on average the past three or four years.

SOURCE: ProPAC analysis.

Chart 3

Change in Hospital Admissions and Occupancy

Year	Admissions	Occupancy Rate	Number of Beds
1981	0.9	76%	986,900
1982	0.0	75	997,700
1983	-0.5	72	1,003,700
1984	-3.7	67	992,600
1985	-4.9	64	974,600
1986	-2.1	63	963,100
1987	-0.6	64	954,500
1988	-0.4	65	942,300
1989	-1.0	65	930,100
1990	-0.5	65	921,400
1991	-1.1	64	911,800

SOURCE: American Hospital Association, National Hospital Panel Survey.

Chart 4

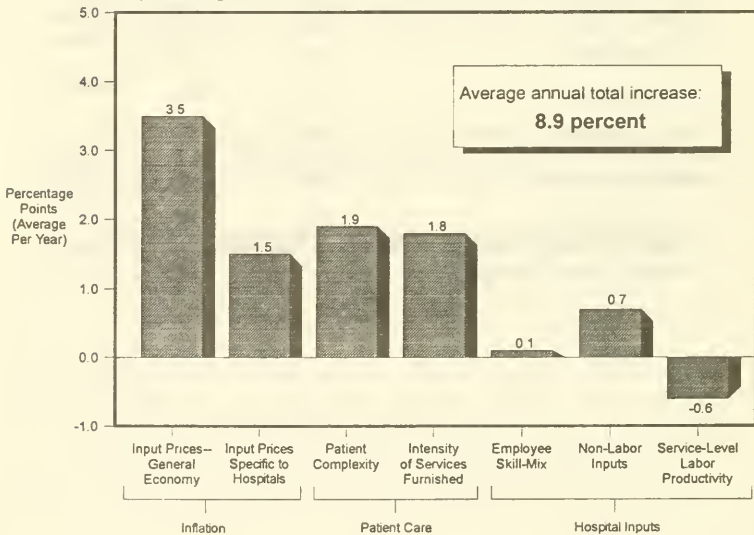
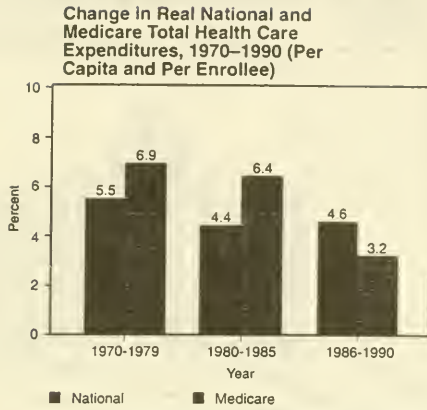
The Contribution of Seven Factors to Inflation in Hospital Operating Cost Per Admission, 1985-1989

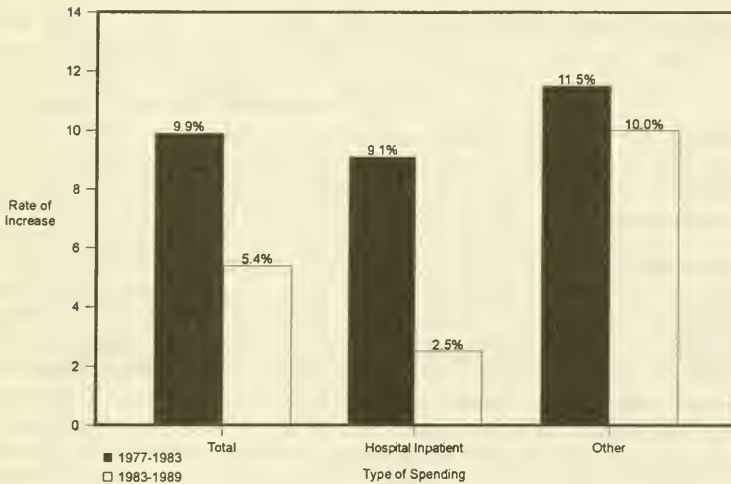
Chart 5



SOURCE: ProPAC updated graph based on information from the Health Care Financing Administration, Office of the Actuary.

Chart 6

Real Rate of Increase in Medicare Benefit Payments, Before and After PPS



SOURCE: Health Care Financing Administration, Office of the Actuary

Chart 7

Cumulative PPS Market Basket Increase, Update, and Increases in PPS Payments and Costs, First Nine Years of PPS

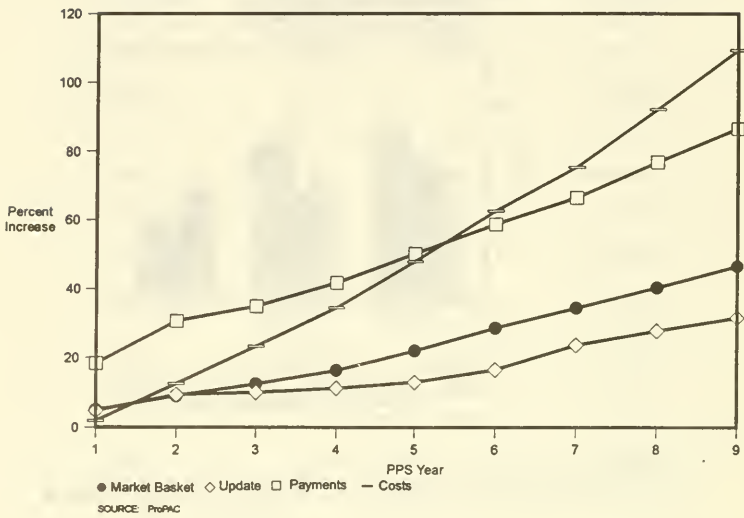


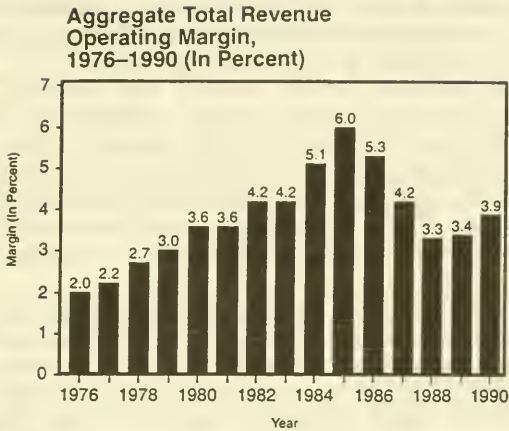
Chart 8

Aggregate Hospital Costs and Payments, 1990

	Cost (In Billions)	Payment (In Billions)	Payment to Cost Ratio
Medicare	\$78.0	\$69.8	90.0%
Medicaid	23.0	18.4	80.0
Uncompensated care	12.1	2.5	21.0
Private payers	81.6	104.1	128.0
Other	8.7	15.8	181.0
Total	203.4	210.6	103.6

SOURCE: Calculated by ProPAC using American Hospital Association Annual Survey data.

Chart 9



SOURCE: American Hospital Association Annual Hospital Survey.

Chairman STARK. Dr. Lee.

**STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN
PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL
GINSBURG, EXECUTIVE DIRECTOR**

Dr. LEE. Mr. Chairman, thank you. I am pleased that you indicated that I am testifying on behalf of the Physician Payment Review Commission, specifically about the growth and expenditures for physician services and I will just briefly summarize the information in the testimony submitted for the record.

Physician expenditures have increased steadily for most of the past 40 years and particularly since the enactment of Medicare and Medicare 28 years ago. In the past decade, that trend has continued. From 1983 to 1992, expenditures for physician services increased from \$61 to \$153 billion, or 11 percent per year.

Nancy Gordon noted in her testimony submitted for the record that the per capita spending for physicians rose from \$295 in 1980 to \$542 in 1990. The portion of personal health care spending as a result devoted to physician services increased from 19.4 percent in 1983 to 21.5 percent in 1992.

And as Bruce Vladeck stated in his testimony, these increases in expenditures are due to price increases and increases in volume or intensity of services or the quantity of services. Price increases are related to general inflation as measured by CPI and medical care price increases above general inflation.

During the 1980 to 1990 period, the CPI component for physician services rose an average of 7.7 percent per year, well above CPI, which averaged 4.7 percent. Medical care prices rose rapidly because of a rapid increase in practice costs, increases in malpractice premiums, and increases in physicians' net income.

Again, Nancy Gordon, in her testimony indicated that net income for physicians after general inflation rose 31 percent in the

period from 1981 to 1989. Changes in billing practices such as up-coding and unbundling may also contribute to the growth of the price component of expenditures. In terms of quantity, increases in quantity are due in small degree to the changes in population—the increased size and the aging of the population. Most significantly, the increase is due to the volume of services per capita.

In the testimony submitted for the record, we describe the increases found at the Medicare program because there the data are the best available. Between 1986 and 1990, for example, the volume of services per enrollee increased by 33 percent or an average rate of increase in excess of 7 percent per year. If this rate of increase continues until the year 2000, the average enrollee would receive twice as many medical services by the year 2000 as was received in 1990.

Procedures that increased most rapidly are described in table 1. Lab tests, cardiac services, diagnostic tests, other medical procedures and endoscopies, increasing from 15.6 for the laboratory, 10.6 percent for an endoscopy. Major surgery and visits grew at slower rates, but because of the large volume of both of these, they contribute almost 59 percent to the increase in volume of services. The procedures that grew most rapidly contributed 37.6 percent and other codes about 3.4 percent.

In table 2, we illustrate those procedures that are growing most rapidly, things like MRI, angioplasty, echocardiograms, and upper GI endoscopy. A number of factors affect the growth in volume: Fee-for-service payment, insured consumers who are insensitive to price, provider-induced demand related to increasing physician supply, and also specialization, and provider-induced demand of the type that was evident 20 years ago when President Nixon froze physician fees. They have also been evident in our preliminary analysis of the volume responses to fee reductions in the Medicare program since 1987.

Technology, which again Nancy Gordon stressed in her response to questions and which has been stressed in a very good paper published last summer authored by Joe Newhouse, the Harvard economist, and that is probably the best analysis of the long-term impact of technology on cost. Defensive medicine has also contributed.

In my testimony, I describe in some detail the impact of the increase in physician supply and specialization, and the impact of technology, and we can respond to questions on that if you wish.

In short, the rising costs of health care pose the most serious challenge to health care reform. If the Congress and the Clinton administration are to grasp an effective health care reform policy, it is critical that we understand why costs have been rising, what factors are amenable to policy interventions and then the impact of proposed policy interventions on those rising costs and the factors affecting the costs.

Thank you, Mr. Chairman.

[The prepared statement follows:]

**STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN,
PHYSICIAN PAYMENT REVIEW COMMISSION**

Mr. Chairman, I am pleased to testify today on behalf of the Physician Payment Review Commission about growth in expenditures for physician services. I will review data on trends in expenditures, analyze its components, and discuss the factors responsible for this growth.

EXPENDITURE TRENDS

The witness from the Congressional Budget Office has given you the latest projections on the growth in health spending relative to gross domestic product (GDP). The portion of personal health expenditures devoted to physician services has been increasing--from 19.4 percent in 1983 to 21.5 percent in 1992. Over this period, spending on physician services increased at a rate of 11 percent per year, from \$61 billion to \$153 billion.

What is behind the high rate of growth in expenditures for physician services? Because expenditures equal the product of prices and quantities, most analysts separate growth in expenditures into these two components. In other words, growth in spending results from increases in prices (dollars paid per service) and increases in the number of services or changes in the mix of services provided. Increases in services can be further separated into those due to growth and aging of the population and those due to changes in the practice of medicine.

Price

During the 1980-1990 period, the consumer price index (CPI) component for physician fees increased an average of 7.7 percent per year. This is a higher rate of growth than that of the overall CPI, which increased at an average rate of 4.7 percent per year. This difference suggests that over the course of the decade, physician fees increased 33 percent beyond general inflation. The physician fee component of the CPI may overstate price growth, however, because it reflects usual charges rather than the discounted fees actually received by physicians. Discounting practices became more widespread during the 1980s.¹

This increase in prices during a period when physician supply was also increasing has surprised many economists. They have taken it as still another indication that the market for physician services is unlike most other markets. Physicians appear to compete on factors other than price, such as quality and amenities, and have substantial abilities to induce demand for their services.

Increasing prices may be due in part to increases in physician practice expenses, such as nonphysician staff payroll, rent, medical equipment and supplies, and malpractice insurance premiums. Practice expenses increased more rapidly than general inflation during the 1980s. The most rapidly growing component has been malpractice premiums, though they declined at the end of the decade. Payroll for nonphysician staff has also increased rapidly, perhaps reflecting increased administrative burdens and increased provision of diagnostic tests and procedures by physicians.

Changes in billing practices, such as unbundling and upcoding, may also be contributing to the growth in the price component of expenditures. Unbundling raises the price if component services are separately billed when billing for a global fee, with a lower total payment, is appropriate. Upcoding refers to the practice of describing a particular service using a code with a higher allowed charge, such as billing for a level 3 rather than a level 2 office visit. Some unbundling and upcoding is inadvertent, and may reflect the ambiguity of codes or billing conventions in a particular area. Neither of these billing practices is reflected in the CPI, however, so this additional portion of expenditure growth due to price

¹ The CPI is being revised to capture the actual fees paid, but earlier data have not been adjusted.

is generally included in the estimate of volume. The magnitude of these practices and whether they have been increasing over time is unclear.

Population Growth

Demographic changes have contributed to rising physician expenditures, but their impact has been relatively small. First, the fact that the U.S. population is growing at 1 percent annually means that there are increasing numbers of consumers of health care services. Given a constant per capita use of services, this population growth would contribute 1 percentage point to expenditure growth annually. Second, as the American population ages, use of health care services increases. CBO has estimated that the quantity of health care services provided will increase by 0.2 percent per year as a result of the changing age distribution.

Volume of Services per Capita

The component that we call volume is that portion of expenditure growth remaining after price and population growth are taken into account. Data from the Medicare program permit the most accurate assessment of volume growth.² Between 1986 and 1990, the volume of services per enrollee increased by 33 percent, or an average rate in excess of 7 percent per year. To put this in perspective, these figures suggest that if this rate of increase continued until the year 2000, the average enrollee would receive twice as much medical care as was received in 1990. Data supplied to the Commission by the Blue Cross and Blue Shield Association for a portion of this time period suggest that volume growth has been at least as rapid for the privately insured population.

The increase in volume per Medicare enrollee was not distributed equally across categories of services (Table 1). For example, laboratory tests, cardiac services and other and medical procedures each increased over 12 percent per year.³ Diagnostic services and endoscopies were the next fastest growing service groups, with annual increases of 9 percent or more. Below-average growth occurred in visits and surgery.

Table 1. Components of Medicare volume increases, per enrollee, 1986-1990.

Category	Average annual rate of change	Percent of volume increase
Visits	5.6	30.2
Lab tests	15.6	8.4
Diagnostic	11.3	10.4
Cardiac services	14.2	8.3
Other medical	14.9	5.8
Endoscopy	10.6	4.7
Surgery	7.8	28.7
All other codes	0.4	3.4

Source: Commission analysis.

² The limitations in CPI data as an indicator of price has led some in the past to underestimate the role that increased volume of services plays in rising national health expenditures. More accurate information on the prices paid by Medicare and some individual private payers permit more accurate estimates of the role that increasing volume of services plays in rising expenditures.

³ Medical procedures include, for example, diagnostic ophthalmological services, injections, pulmonary evaluations, and electroencephalograms.

Within these service categories, there are some services that experienced tremendous volume growth (Table 2). For example, the volume of magnetic resonance imaging (MRI), a technology that was just becoming available in the mid-1980s, increased 57 percent annually between 1986 and 1990. Cardiac angioplasty increased 29 percent per year. In contrast, lens replacement for cataracts, which had grown a great deal during the mid-1980s, tapered off during the latter part of the decade.

Table 2. Medicare volume increases for selected services, per enrollee, 1986-1990.

Category	Average annual rate of change	Percent of volume increase
MRI	57.4	1.1
Angioplasty	29.0	0.8
Upper GI endoscopy	12.0	1.4
Echocardiogram	25.6	1.6
Cataract lens replacement	7.7	5.8

Source: Commission analysis.

The total contribution of each service category to volume growth results from both the category's annual rate of increase and its share of total services. Therefore, some categories, such as surgery and visits, have a large contribution to total growth despite their relatively low growth rates. These two categories accounted for well over half of the total volume growth between 1986 and 1990.

FACTORS AFFECTING VOLUME

Growth in volume appears to stem from multiple forces that are changing the way medicine is practiced. The predominance of fee for service as a mode of payment provides physicians with an incentive to provide all services that might be of benefit to the patient. While elementary economics would predict that the quantity of services demanded will decline when prices increase, the presence of third party payment has made many consumers substantially indifferent to the amount of care prescribed and its price. This unconstrained environment permits factors such as increasing physician supply and technological change to increase spending substantially.

Physicians appear to have significant ability to induce demand for their services. This has meant that an increasing supply of physicians can increase the volume of services provided without reducing prices. Many believe that growth in the physician supply since the 1960s has contributed to expenditure growth. This could happen if the additional physicians are able to serve patients whose demand was previously unmet or if physicians induce demand for more services to maintain income levels in the face of an increased supply.

Between 1970 and 1990, the number of physicians per capita increased over 50 percent. These trends are expected to continue through the year 2000 and beyond. If expenditures per physician and the physician-to-population ratio both continue to grow at current rates,

total expenditures as a percent of GNP could double between 1986 and the end of this decade.⁴

Another factor that may be contributing to expenditure growth is the increasing specialization of physicians. The proportion of the physician workforce in medical subspecialties (such as cardiology and gastroenterology) doubled between 1970 and 1990. Specialization may push up expenditures for two reasons. First, specialists have higher revenues than primary care physicians, reflecting in part the inequities in relative payment of the current payment system. Second, many believe that management of a medical problem by a specialist results in the provision of more intensive services for the same problem than is the case for a primary care physician.

Physicians' ability to induce demand also leads to increases in the volume of services partially offsetting fee cuts. The pattern has been observed in Canada and Germany and, recently, in the Medicare program. Research by the Commission into the impact of reductions in payment rates for overvalued procedures that were implemented in 1988, 1990, and 1991 show that in geographic areas where reductions were larger, volume increases were higher. On average, the estimated offsets were somewhat under 50 percent. The magnitude of these offsets vary by type of service, with surgical procedures appearing to have a smaller response than medical procedures, and by year, with the 1991 offsets appearing to be smaller than those estimated for the earlier years.

These estimates are for short-term responses to these changes. Long-term responses may be different. Research is currently underway by the Commission on volume responses to changes in payment rates associated with the implementation of the Medicare Fee Schedule in 1992. This research is expected to not only shed light on the response to subsequent reductions in payment rates for some services but also to estimate the response to payment rate increases for other services. These results may indicate whether the Health Care Financing Administration's assumptions underlying the Fee Schedule conversion factor were correct. Research is also underway on whether the volume of services to privately-insured patients were affected by Medicare changes in payment rates.

Americans have long been fascinated by the power of science and technology to provide solutions to societal problems. This is readily apparent in the health sector, where lasers, fiberoptics and other new technologies are increasingly being used for diagnosis and treatment. The introduction and diffusion of these new products and processes may increase expenditures if they substitute for less expensive services or provide new opportunities for diagnosis and treatment. This may have a rippling effect on the practice of medicine as technologies move from hospitals to physicians' offices and as existing technologies are put to new uses. Heightened expectations and price insensitivity on the part of consumers and providers create an environment in which new technologies are readily adopted, even when the benefits are small.

Medicine is changing rapidly and the implications of its increasingly technological nature are not well understood. While many Americans have ready access to the most advanced technologies, there is a downside to this. Rapid diffusion of technologies without careful assessment of their benefits and risks may result in care that provides little benefit or is harmful to patients. The precise impact of this inappropriate care on expenditures is not known and estimates of its level and rate of growth vary widely. A recent article by Joseph

⁴ Grumbach, Kevin, and Philip R. Lee, "How Many Physicians Can We Afford?," *Journal of the American Medical Association* 265(18):2369-2372, May 8, 1991.

Newhouse argues persuasively that more than 50 percent of health expenditure increases are related to technological change.³

Similarly, some of these uses of new technology may be primarily defensive -- that is they may be ordered to provide protection against claims of malpractice rather than to meet a particular patient's clinical needs. This may be particularly true for certain services such as imaging (CT scans and MRIs), diagnostic tests such as cardiac stress tests and chest x-rays, and cesarean deliveries. The costs of defensive medicine have been very difficult to measure accurately. Our sense of the limited literature is that the costs of defensive medicine are important and malpractice reform should be pursued. But a substantial reduction of defensive medicine would still leave expenditures at levels that are way too high.

To close, the need to contain costs is not new; it has been a priority at least since the late 1960s. While many steps have been taken, success to date has been modest. The experience has taught us that there is not a single "magic bullet" to contain costs and that approaches must be pursued vigorously if they are to succeed. Success will not come easily, but the price of failure will surely be an awesome one.

³ Newhouse, Joseph P., "Medical Care Costs: How Much Welfare Lost?" *Journal of Economic Perspectives*, 6:3, Summer 1992.

Chairman STARK. Thank you both. I am trying to frame this question in as an objective way as I can without providing the answer. So I am going to say within 5 years, given that we want to operate in a reasonable timeframe for making major policy changes, that the delivery system, for a host of reasons, is not going to tolerate, whether it is on the part of the patients or the providers or politicians, vast changes in how we structure the health care system. We will not go entirely to capitation, or we will not go entirely to fee-for-service, nor entirely to a Government plan, but that we will probably try and use delivery systems with which both the providers and the patients are familiar.

And given the fact that we have to be able to satisfy the Budget Office and/or the insurance companies and/or the bean counters, either in private industry or in the Government, that we are, in fact, controlling the rate of increase of costs. Because I think it is safe to say that if we just cut down the rate of increase by, say, 2 percentage points, the Medicare trust funds would be solvent probably for all foreseeable time and we could declare victory.

Given those limitations, the Chair has felt that the only system we know, although there may be others, is a system, similar to the Medicare system, for both establishing rates, for accounting for them, for projecting them and so forth, although not necessarily Medicare rates.

I would ask each of you in turn, Bruce, and then Phil, to comment on how you think that would work if we applied it as a system to the present medical delivery system. Could we control costs and find savings? Would we continue to have quality medical

care, or could we, in this country? And is there something that is obvious or that is on the horizon that would be a much better way to approach the health care system than using the old tried and true Medicare system?

Bruce, do you want to respond?

Mr. VLADECK. Mr. Chairman, I think, as you know, at the request of this subcommittee, both of our commissions last year looked at a proposal to extend in a partial way, on a voluntary basis the Medicare price setting system to the private sector by permitting private payers to voluntarily choose to pay Medicare rates, and we found that one couldn't do it all in one fell swoop because the difference, all of what Medicare is now paying and private insurers are now paying is so substantial that the effects would be extraordinary.

But it does suggest to you, having looked at the commission over the years at the impact of the Medicare payment limitations on the quality of services received by beneficiaries, on patterns of services received by beneficiaries, on outcomes experienced by beneficiaries, that we are paying a premium in the health care system in the United States for not being tougher about prices, not having the payers be tougher about prices relative to the sellers.

In a sense, we have set up a market in which, for a variety of reasons, the sellers have been told by a large portion of the purchasers, we will pay whatever you charge, and they have behaved accordingly.

I personally believe—and I can't say I speak for the whole commission on this—that a large part of our problem in health care costs is a pure price cost which pays out into the incomes of people who work in the health care sector, starting with physicians, but including hospital administrators. And nurses and social workers in hospitals make \$10,000 more a year than social workers in child care agencies with the same kind of background. And that is a price effect.

And if we could find some mechanism to negotiate, because there is some science, but not pure science, to really negotiate prices between sellers and buyers, we could have a major dent on the rate of cost increases.

Chairman STARK. Phil.

Dr. LEE. As Bruce indicated, the commission did a study for this committee that indicated that applying the Medicare fee schedule to the private sector is much easier than applying DRGs because of the fee-for-service system and the fact that many of the insurance companies are, in fact, already beginning to apply that in some of their—particularly managed care plans.

The problem that Bruce noted, the difference in current levels of payment, could be overcome with a different conversion factor, which then could gradually be brought toward the Medicare fee schedule. Applying the fee schedule would have an effect on expenditures. We need to make further improvements in the fee schedule if we are to level the playing field and have a more appropriate level of payment for evaluation and management services compared to procedural services.

The second question you asked has to do with the quality of care. Congressman Andrews, in his questions to Nancy Gordon, raised

the question, and I believe that there are serious quality problems. They have been identified. There is a good deal of care that is either inappropriate or unnecessary. Much of it is costly. The issue that you have identified for several years, Mr. Chairman, the question of self-referral, is particularly important. It is a serious problem when you have many more services provided, four times as many in some cases, when self-referral, particularly for imaging services is carried out. The extra services are in most cases unnecessary and costly. That is poor quality care. There are many, many other examples.

The fee-for-service system has serious quality problems now. We don't have an adequate system yet, either for continuous quality improvement or to do the kinds of outcome measures that Congressman Andrews identified as critically important. The development of data systems, providing information to physicians, and having an accountable system is going to be absolutely essential.

And how we achieve that, whether it is fee-for-service or in organized health care systems with regulation of plans as opposed to providers, we will need the data. And Nancy Gordon again spoke about that. That is a major area of development which we must pursue to assure quality.

Finally, are there better ways? If we look at where we want to be in, let's say, 2010, or even 7 years from now in the year 2000, the question is: Do we want to have a fee-for-service system with increasing price controls, increasing physician supply and more technology?

I think we have to explore alternatives and, as a former physician in a group practice, I will speak for myself on this one. I believe that the approaches to organized systems of care, multispecialty group practice, in some cases some of the innovations that have developed with respect to primary care networks, provide some ideas and visions about the future that may be preferable to what we have today.

And if that can be developed, we might be able to achieve more effective cost containment with quality assurance.

Chairman STARK. Thank you. Thank you very much. I just would announce to the members that we will continue to work. The members may wish to answer the vote as they have time and as they schedule their inquiry.

I recognize Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. Dr. Vladeck, on your chart 8, which clearly shows that there is a degree of cost shifting going on, how comfortable are you in terms of your ability to produce statistics which you feel comfortable in terms of what you have done in the Medicare area and to arguing that if there wasn't a bulge or a push, that is, if you could control the whole system, that you could see the kinds of reductions in the whole system that you could in Medicare? Because obviously folks have been sliding rather than digging in and making changes perhaps.

Mr. VLADECK. Mr. Thomas, I didn't do this intentionally, but I did not, in my remarks, refer to chart 7 which I think speaks in part to at least the commission's position on this issue. Part of the reason I didn't refer to it before is it is sort of complicated and it

takes awhile to talk about, but if you will see, of these four lines, the one that goes fastest is costs.

You will also see the one with the black circles in it represents the estimate of the market basket that we produce every year and that HCFA produces every year. The difference is the growth over inflation. Now, payments is the square boxes, is the update factor plus case mix growth. So costs are growing faster than inflation plus changes in patient characteristics for hospitals on average.

Now, we think that over the life of PPS, we believe that this Congress has always acted in perfect wisdom every year with its legislation on the update factor, that the original PPS rates were quite generous, and the update since then, we think, represent a reasonable set of expectations in terms of public policy for anything the Government buys or any industry, a rate of growth, and yet costs have grown twice as fast as that increase in prices.

Mr. THOMAS. For Dr. Lee, as well as yourself, on chart 2, it is pretty obvious—I don't know what the other professional services entail, but in terms of the physician services, if you are going to squeeze me on the costs, I can simply run in place faster, which is the volume aspect. And could I get a quick answer from you—which is totally unfair, I know—but you can have a volume increase as either a reason or an excuse on the basis of cost controls, that I am getting less per procedure so I will do more procedures and the amount remains the same, or you can get an increase in volume either as a reason or excuse on the basis of technology.

We have a whole lot of assistance here with new machinery and the rest, so we do a whole lot more, or you get a volume increase because of malpractice, that I am covering myself from a defensive point of view, so my downside is not as high.

Is there any way to estimate or give some indication as to whether or not the volume increase is—I know the answer is it is a combination of all three, but in terms of where the emphasis might be? Is there any intuition on this in terms of simply increased procedures or technology primarily driven or if we did something with malpractice, we could see a significant drop in the volume increases because of the need to protect this.

Dr. LEE. Well, the data that we have provided this committee would suggest—and certainly the studies that professor Newhouse has done at Harvard over time would suggest—that technology plays a major role in these volume increases and, therefore, the expenditure increases—the new technologies and expanded use of the existing technologies. You take laboratory testing—

Mr. THOMAS. Can you put a percentage on it?

Dr. LEE. Well, Joe Newhouse estimated that at least 50 percent of the increased costs over the last 40 years were due to technology. All the other factors combined are less than that and maybe even—you know, certainly less than 50 percent.

Mr. THOMAS. Here is my concern: If in fact that is the case, 50 percent or more is on technology. If we are talking about trying to get a handle on this problem, we can have Government move in and pick X, Y, or Z as far as price is concerned and that is what it is going to be, and people can adjust career plans. But if 50 percent or more of it is driven by technology, I am nervous about going in and deciding from a government fiat point of view what technol-

gies are going to be denied to people if we are going to get a handle on it.

So one of the things I am very concerned about as we get into this area is, I think one of the best ways to control a technology choice is a marketplace concept of what people are willing to pay for, so that technology continues to be available in new and available forms, but then it is a price consideration by people who make the choice, rather than Government saying that this technology or that technology is not going to be used.

Dr. LEE. It is critical that the Government have a role. First of all, take prescription drugs. As the consumer, if you didn't have the FDA, how would you decide what is a safe and effective drug? So we have to have a substantial role for the Government in technology assessment, as we do for prescription drugs. We do for medical devices, but to a lesser extent.

Mr. THOMAS. A significant role and a defining user to me are two significantly different things.

Dr. LEE. What is the role for Government? What is the role for the purchaser? And then what is the role for the individual consumer?

The second area that is not regulated well, and where there is significant overuse of technology, is in procedures. We have procedures that have come into the marketplace with very little study of their effectiveness, or even their safety. So that is a second area, I mean a broadening of that role.

Mr. THOMAS. But that is a problem of getting standardization so that you can compare and have objective evaluations of the incremental advantage of one procedure over another. I can get on top of that from Government refereeing the structure and making decisions about the efficacy of one treatment over another. Talking about the fundamental question of technology and whether you use something or not and Government making the decision that it simply costs too much, because from this side of the dais, let me tell you, those kinds of decisions are not going to be made by my colleagues.

Mr. VLADECK. If I can respond to that for a minute, it has always struck me as curious that in every other industry, when we talk about the impact of technology, we are talking about it to increase the productivity or reduce production costs for some outcome, yet we talk in health care about technologies increasing cost.

I would argue, that's because of the way in which we pay for technology in health care. We don't pay for a product, whether it is a bundle of services associated with a visit. We do pay now for a product that is a hospital discharge, but we pay extra every time a technology is used.

It is as though when you went to fly home, the airline says, if you want a jet, we are going to bill you separately. First, there is air transportation, then there is a jet, then there is whatever. So I think, in fact, that technology is not an autonomous force.

Technology is very sensitive to changes in economic patterns of demand, and if we had a market or a system in health care that produced greater discipline on sellers, whether that discipline was through control of prices or mobilized consumers or any of a

number of things one can imagine, you would find the suppliers of technology selling different things to providers.

Mr. THOMAS. Let's focus on that. And this will obviously require additional information later, and if you want to give it to me, I would appreciate it. So what we want to do is turn technology to our advantage in terms of a cost-saving procedure where choices are made to use the new technology because it allows you to do more for less, and therefore I get more profit.

Do you believe that either the price-control imposed universal structure of one model versus the competition model presages a better chance for this reverse use of technology in the medical area as opposed to other areas?

Mr. VLADECK. I believe that if you set up a situation, Mr. Thomas, in which individual consumers can be told by marketers that their family can have access to the latest and best technology only if they pay an additional amount out-of-pocket, you will create a marketplace phenomenon not unlike what we currently have in which the effect of technology in that sort of market is to drive up prices and costs over time.

I think the only way we can make technology work to our benefit, whether it is a managed competition or regulated¹ is to set a price per household or a price per patient over a period of time and leave the determination of what technologies are to be employed to providers operating under budget constraints rather than to individual households and salesmen.

Dr. LEE. Let me just give you an example of a technology procedure where informing the patient significantly reduces the use of that technology. In the Kaiser Permanente Health Care Plan, Jack Winberg at Dartmouth has developed an interactive video disk to inform patients about the transurethral resection of the prostate (TURP), the pros and cons, and a great deal of information about it.

When in two studies that information was given to the patient in a capitated prepayment plan—when the patient pays no more whether they get the surgery or not—it reduced the volume of those operations by 50 percent. We are not currently providing information to patients about the risks of technology.

Most of us as patients are much more risk adverse than the physicians who are recommending those technologies, whether it is a drug that may have some serious side-effects, or whether it is a procedure, so that that information for consumers is very important.

One of the appealing things to the proposals for HIPCs, or the Health Insurance Purchasing Cooperatives, is the information that they would provide patients or require providers to provide, and there we have a role for the plan with respect to selection of technology as well as the actual providers. But we will try to put some additional ideas together for you in response to that question.

Mr. THOMAS. Thank you.

[Additional information follows:]

The HIPC, in addition to its role in administering the system, could be expected to play a more active role in managing the competition. In this conception, the HIPC could work to encourage plans and practitioners to respond to the competitive marketplace in ways that guarantee appropriate care. The HIPC could use such

levers as the rules for plan eligibility, the data required to compare plans, or general oversight authority to encourage cost-containment activities that distinguish between appropriate and inappropriate care.

In this expanded role, the HIPC could play an active role in a community's health care delivery, targeting areas where inappropriate care is common or initiating projects to improve the delivery of care. In particular, the HIPC could (1) implement the use of selective contracting for certain costly procedures, (2) convene physicians to address areas of inappropriate care identified through use of profiling, (3) initiate or support programs to implement practice guidelines, or (4) urge plans either to make decisions about the appropriate use of technology or to place some of this decisionmaking in the hands of enrollees. The HIPC could require plan involvement in these activities as a condition for being selected in a given region.

In addition, plans could be held accountable through the quality performance measures they would be required to submit for use by consumers in selecting plans. These data could include a record of a plan's participation in community activities aimed at encouraging appropriate care. The data might also reflect decisions made by the plan about the appropriate use of technology. In this way, consumers could have the basis to choose between a plan that used a particular technology more aggressively and one that was more conservative in this respect.

Mr. McDERMOTT [presiding]. We are talking about how the wrong incentives in the health care system are forcing the costs of care up.

The wrong incentives really start right in the medical education setting. Over the last 25 years, at least in my experience, the funding of medical schools has changed dramatically.

Historically, physicians in medical teaching settings were funded by a combination of government support of medical schools and student tuition—not earning their own income by performing professional services and being paid for it.

It is my impression that this has changed, that State legislators have backed away, we have taken away money out of Medicare, and we have put medical schools in the position of saying to their faculty, go out and raise your own salaries. In doing that, we have set them on the path to earn as much money as possible. Not surprisingly, they choose to practice tertiary care settings requiring sophisticated technology.

I would like to know whether there has been a change in the financing of medical schools in terms of the proportion raised by tuition or the portion raised by physicians' fees or the portion paid for by Government.

Dr. LEE. Mr. Chairman, I have just had a chart sent up to you which I hope is in front of you, which is, "Trends and Sources of Medical School Revenues from 1960 to 1990" as a percentage of total revenues. And this was an article published in the Journal of the American Medical Association in September of 1992.

In 1960, tuition and medical services represented each 6.4 percent of the revenues for, then, 85 medical schools. The total revenues in that year were \$1.925 billion. By 1990, tuition and fees represented 4.2 percent of income and medical services 44.8 percent. Now, that increase was most rapid in the period from 1970 to 1990 when the medical service income went up from 12.2 to 44.8 percent. So there has been a dramatic change in the source of income for the medical schools.

The medical practice plans now are the major source of revenue. Federal research, which in 1960 was 30 percent, is now down to 19.2 percent. State and local governments, which were 17 percent, actually rose to 23 percent in 1980, are now 14.1 percent, so that

the point you are making is the environment in the medical school for teaching, what do the medical students and residents see?

They see the faculty engaged heavily in practice, generating revenue, and many of those, of course, are in tertiary care centers specializing in the care of very sick patients with complicated problems requiring the use of very high technology.

Mr. VLADECK. If I may add one word on that, because it is worse than that in a sense. I know that this subcommittee and both of our commissions have spoken about the issue of beginning to redress some of the imbalance in medical manpower through the reimbursement tools available to us in the Medicare program.

In fact, if you look at the issue, for example, of limiting indirect or direct graduate medical education payments to hospitals for training very high tech subspecialties and try to tilt the money in favor of family practitioners and other generalists, among the things you find is that the cardiology fellowships, the nephrology fellowships, gastroenterology fellowships or last year's medical programs are so lucrative for the medical centers that if you pull the graduate medical education reimbursement dollars out, they would continue to do that.

That is not to say you might not want to change the reimbursement. But this has become a self-reinforcing driving engine that is increasingly immune from those policy levers we have to use in the Medicare program, and suggests again the need for a more comprehensive look at a lot of them.

Dr. LEE. Another example of that, Ken Melman, who was chairman of medicine at Stanford, did a study of sources of revenue for departments of medicine. This is an unpublished study, but if I remember the study, 60 percent of revenues from the department of medicine came from cardiology. So it behooves departments of medicine, because of the incentives in the payment system, to create specialty training programs to provide the services that then generate those revenues that support, let's say, general medicine, which may be a money-losing residency program and money-losing faculty source of revenue.

Mr. McDERMOTT. Do you think we can do health care reform, serious health care reform without looking at the question of manpower and how it's educated?

Dr. LEE. I would say absolutely not. And we have to look not only at physicians but also nurses. In many areas of primary care and many specialty areas, clinical nurse specialists or nurse practitioners—and in some cases physician assistants—are able to perform the same functions performed by physicians or working with them as a team to enhance both the quality and access to care for services.

Mr. McDERMOTT. Thank you.

Mr. VLADECK. Frankly, I am somewhat more skeptical. I believe that physicians or physicians in training or potential physicians are extremely bright and adaptive folks. And if we get the payment signals right on the basic care system, it won't take long for physicians themselves to begin to change their specialty choices or their behaviors or their practice patterns to fit with that new system. I think we can do it perhaps a little more indirectly.

Mr. McDERMOTT. Are you talking about loan forgiveness programs or are you talking simply about what we pay for?

Mr. VLADECK. I am talking about what we pay for. I think if we add more rational payment systems, the hemorrhaging of specialists into specialty medicine would be substantially reduced. People would start choosing primary care careers if their income expectations were comparable to what people entering specialty careers have.

Dr. LEE. You have to look at the experience of other countries. All the major European countries, as well as Canada, have limited the choice of residency positions because they are paid for by government. In Canada, they pay for residency training because it is education, not because it is a service provided to patients, so that those training programs are designed to meet the educational needs and then the needs of the public as opposed to the needs of the individual who is in training.

Mr. McDERMOTT. Thank you. Mr. Kleczka.

Mr. KLECZKA. I will followup on Jim McDermott's question for either Dr. Lee or Dr. Vladeck. If, in fact, we or the marketplace increase the salaries for general practitioners to the level of specialists, knowing full well we are going to need more GPs than specialists, where are we going to extract any cost savings? And do you think that the specialists at that point are going to take less than the GPs?

Mr. VLADECK. There are two issues, one is relative prices. The expense associated with specialists—and Dr. Lee can probably give you more data—are not just their incomes. It is the volume of procedures and tests and technologies and surgical interventions to which their incomes are tied.

We have joked in the past that we might do something more effective about medical care costs if we followed the example of agricultural policy and paid a certain class of surgeons not to do operations.

Mr. KLECZKA. I didn't ask for the worst model. We had a dairy buyout program and every retiring farmer in the United States contacted the Government. So let's not use that as a model, please. Or the crop program. You put into the bank the worst land that won't even grow anything and on productive land, then you really go whole hog with corn and wheat and everything else. So bad example. Find another one.

Mr. VLADECK. If we get the worst surgeons all to retire, we might come out ahead. I think the issue though, sir, is—

Mr. KLECZKA. That is my next question, malpractice. But go ahead.

Mr. VLADECK. About 20 percent of total expenditures are directly payments to physicians, but physicians through their ordering behavior account for a considerably larger part of expenditures, the charges for laboratories, for prescription drugs, for many of the costs incurred by hospitals are the result of physician choices and physicians' practice patterns.

So if you reduce the volume of various procedures in intensive medicine, both inside the hospital and outside the hospital, you can maintain the level of physician incomes for specialists and still save a lot of money.

Mr. KLECZKA. Dr. Lee, a quick question: Has the PPRC determined what portion of the volume increase in physician services is attributable to defensive medicine, defensive practices?

Dr. LEE. It is really impossible to determine that. There have been some estimates made, but I think that the studies don't really give us an accurate picture. In my own view, it would be almost impossible to determine that because these are clinical decisions that are made often in emergency rooms or various other settings.

And what is a necessary procedure under those circumstances versus one that the doctor's thinking in the back of his mind, maybe this will help me protect against malpractice, would be very, very difficult to sort out.

Mr. KLECZKA. But in your experience, you would take a guess that that does occur and there is some type of a cost, maybe a high cost associated with it?

Dr. LEE. I would say it is a cost, but I don't think it is a high cost. I think it is definitely a cost. Some people have estimated it might be as high as 10 or 15 percent of the physician expenditures, which then if you are talking about 10 percent of 20 percent, you are down to 2 percent of the costs. That is not insignificant if in fact that is what it is. But we really don't know accurately how much is due to defensive medicine.

Mr. KLECZKA. Do you have any guesstimate as far as what percentage of our total national medical costs are attributed to the malpractice problem or issue? The reason I ask that, because we are told by many, or I am told by many doctors, that if we can resolve the malpractice problem, we can reduce medical expenditures by x amount of billions, which I don't know if that is true or not.

Dr. LEE. The commission did recommend to Congress reforms in malpractice and recommended some choices in that regard, and we believe that a reform in the malpractice system is important, but it is not a panacea by any means. Far more important than modifying the tort system is to do something about the quality of care in the institutions.

Most patients who are victims of medical negligence never sue the doctor, never get a payment, and if we could reduce that problem, we would make a much bigger contribution, so that focusing on quality is a far more important way to approach that problem, to reduce the negligence, reduce the medical injury as opposed to malpractice reform, even though we favor the latter as well.

Mr. KLECZKA. What is the California experience as it relates to malpractice?

Dr. LEE. California, with the tort reforms that they have instituted, have significantly reduced the premium increases for physicians. But I don't think we have any evidence about what has happened to the quality of care that is provided patients in institutions.

Mr. VLADECK. If I can pick up on that for 1 second.

Mr. KLECZKA. If the chairman will permit.

Chairman STARK. Yes.

Mr. VLADECK. For the last 3 or 4 years, the total number of malpractice claims has gone down, largely because of tort reform in a number of States. Premiums have risen less than inflation for most medical specialties in most States over the last several years. The

economic impact of the direct costs of malpractice insurance has fallen and yet you can see what has happened to total costs overall.

So while there may be a fair amount of defensive medicine and malpractice insurance in the base of our costs, it is clear that over the last 3 or 4 years, that has not been a significant contributor to the increases, because in fact the actual costs for the malpractice system have been going down during that period.

Mr. KLECZKA. Thank you very much.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Well, just to follow up quickly on the malpractice question, I don't think anyone can quantify the amount of money spent in the health care system due to doctors practicing defensive medicine. And so even though malpractice premiums may have stabilized because of tort reform, it doesn't say anything about the practice of physicians who have become accustomed to guarding against lawsuits.

I would hope that any comprehensive plan that this committee develops would include some kind of national malpractice reform. That is not a panacea, I agree, but certainly it is a component, I would think, of any comprehensive reform plan.

Dr. LEE. The commission, I think, would certainly agree with that assessment and, as I said, did last year make fairly detailed recommendations.

Mr. MCCRERY. I am on my budget kick today and I couldn't help but notice, I think Dr. Young particularly, when I was asking Dr. Gordon about the impact on Medicare and Medicaid costs in the out-years, of reducing the underlying general health care costs, and I sense that you all had something to say on that. If you do, I would like for you to share that with us.

Mr. VLADECK. It would probably be impossible to quantify, sir, but our sense on a year-to-year basis, as we look at the growth in Medicare hospital payments under the prospective payment system, is that, again, it is very hard to be totally disconnected from what is going on in the rest of the system.

And therefore, in a sense, I think it is accurate to say that we feel ourselves constrained in terms of the recommendations we make to you about the year-to-year updates in Medicare payments because of what is happening in the overall sector, in the private sector.

And, again, the fact is, if hospitals, because they can cost shift at the moment, give nurses 15 and 18 and 20 percent salary increases and then ripple that down all the way through their whole payroll in the institution—and institutions are looking at 15 or 18 or 20 percent payroll increases in costs—it is very hard for Medicare not to be affected. First of all, that does plug into our measure of the market basket and it does plug into some of what we do in Medicare increases.

But it is very hard for us then to say you shouldn't be permitted any of that increase because hospitals say this is the labor market we are in. Well, they are in that labor market because there is no organization to the market and the sellers have this monopoly power on their part. So over time, our ability to control Medicare spending is limited. With Medicaid, if I may, the issue is even more explicit because there is legislation that says that the Medicaid

payment rates to hospitals and certain categories of physicians have to be tied to what is going on in the rest of the market in the Boren amendment.

Our ability to control Medicare and Medicaid outlays is very much limited, we believe, by the growth in costs, even to the extent in the short term they are shifted to the private sector.

Dr. LEE. With respect to physicians, we would absolutely agree with that. One of the problems is, as you reduce the price that Medicare pays, and this subcommittee of course plays the key policy role in that area, you will increase the difference between what Medicare pays and what private payers pay.

And that will both increase the volume of services provided, resulting in unnecessary care, we believe. But more importantly, it will impair access to the Medicare beneficiary at some point.

At some point when that price drops too far below the price that the private payers pay, the Medicare patient is going to have increasingly limited access as Medicaid patients do in many States, and to me that is the overwhelming reason.

We need to control cost, with respect to Medicare, in a very few years. Unless costs are contained in the whole system, the Medicare cost reductions will have hit the maximum that you can achieve and then everybody is in the same boat. And the cost shifting that Bruce mentioned has clearly gone on, but the access question is going to be the more serious one in a few years.

Mr. McCRERY. With respect to the—I mean, let's isolate the access problem right now and just talk about the budget impact on the Federal Government. Is it safe to say that, in your opinion, probably the most important thing we could do as a society in terms of getting the budget deficit down with respect to Medicare and Medicaid costs is to get the underlying health care costs in the system down?

Dr. LEE. I believe that, and if you look at the general revenues, which support 75 percent of course of the physician expenditures in Medicare, it is clear that the physician payments have a particularly serious impact on the Federal budget deficit. And the rate of growth that Nancy Gordon projected for the increased percentage of the Federal budget for medical care expenditures indicates how serious that problem is.

Mr. VLADECK. Could I make one little additional point because it was discussed? To the extent that part A is financed from payroll taxes, and to the extent that over the last decade we haven't given people cash wages because we have been increasing what we pay for their health care premiums, and there is a tradeoff with and without a tax subsidy in that regard, and to the extent you can put employee compensation in cash rather than health insurance premiums, not only are you presumably doing something about the prices of health care, but you are increasing the revenues to both of your trust funds.

Mr. McCRERY. Thank you.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Gentlemen, are either one or both of you aware of the lamater project in Cincinnati?

Mr. VLADECK. Mr. Grandy, if I may say so, I was—we were both at a meeting yesterday in which someone from this city told us about the Iamater project as the most exciting example of the prototype of managed competition in the United States and how every large employer in Cincinnati was participating.

And it just so happened that at that meeting was a representative of the largest employer in the city of Cincinnati who said they were not participating and they thought it was a bunch of hoopla. Now, that is a secondhand kind of discussion.

Mr. GRANDY. Pretty good comment, though. Can I infer that you are not that excited about it?

Mr. VLADECK. I can only report this conversation. I haven't studied it firsthand, but from the description, I am as in every aspect of our life, struck by the difference between what the vendors of Data System claim their system will be able to do and what we have actually been able to do with them.

Dr. LEE. We have not examined that program at all from the commission, so I really cannot comment. Although as Bruce indicated, he and I were both at this same meeting where the comment was made, but, again, the commission has no firsthand knowledge.

Mr. GRANDY. Let me just tell you where I am coming from. Some members of this committee, I think it turned out being the four Republican members, although everyone was invited, went to a presentation of this project in which they obviously thought this was the bow spread of an enlightened era of managed competition in which, not only were costs contained, but—quality was not only maintained, but the—I guess the continuous quality improvement, the CQI, rose quite distinctly.

Now in the room you had employers, not the least of which were people like Procter & Gamble, some other pretty sizable Cincinnati employers, Crocker Foods, and the physicians who run this. And I believe that just about every hospital in Cincinnati is involved. The whole idea was this was a private sector regulation model which would do all of the things that this committee is going to try and struggle with, to not compromise quality by solving containment and access.

My question is general. You have already said that you don't think this is a workable deal in Cincinnati, you doubt it at the presentation yesterday. Is it a model—and I guess I am citing the President's example right now for the national health care system for this country—or are we wasting our time? Should we be talking more about a kind of top-down regulatory price control system?

Mr. VLADECK. The question is: What is a model?

Mr. GRANDY. Managed competition where you have physicians and employers contracting to deliver quality services at reasonable rates. They are policing themselves in other words.

Mr. VLADECK. If I may, my experience to date has been that every model of managed competition, first, is still in evolution and not yet where its proponents say it should be; and second, is different from every other model of managed competition. So if you point to the benefit plan at Stanford University or if you point to the Federal Employee Health Benefits Program as all prototypes of managed competition, they are radically different systems for the

purchase of health care and arrangements for the provision of health service.

I guess I would say that if you envisioned a circumstance that fits with the theoretical statement of what is occurring in Cincinnati or going to occur somewhere else, there is an awful lot to be said for it, provided you make three assumptions. One is that you really can generate data on the quality performance of plans and the cost effectiveness of plans, which again we haven't looked at the Cincinnati data in any detail, but I haven't seen it from anywhere else.

Mr. GRANDY. Let me stop you there. Do you believe data can be generated?

Mr. VLADECK. Good data that is useful can be generated about the quality. Somebody who measures the quality of care, having lived with that process of trying to develop that data over the last 15 years, if we quadrupled the rate of speed with which we are developing the data methodologies, it will be another 50 years before we do it.

I think there are some serious theoretical problems toward developing the data, conceptual problems, and I think we lose sight of how fast norms of accepted high quality practice change, given the rates of scientific and technological change in medicine. And the social scientists are always going to be three steps behind the physicians who are themselves two steps behind the laboratory. So I think that is a great assumption. I could be wrong, but we have not proven the contrary yet.

Second, what you are talking about in these models is a *prima facie* violation of the Sherman Act. So you are talking about writing a set of legal standards that would permit certain kinds of anti-competitive behavior to permit the sharing of this data and so forth that raise serious questions, I think, about liability and about regulatory responsibility, which you could address, but I think would have to be thought through. This is not a system that runs itself or takes care of itself as even its most ardent proponents would say.

Mr. GRANDY. You raised an interesting point. Would you say that, based on the conceptual model of the President or the Conservative Democratic Forum advanced or even the action advanced by the Republican Conference last year, are they in violation of the Sherman Act?

Mr. VLADECK. No, because they are talking about statutes that would specifically provide exemptions by providing an elaborate alternative program. If you read the CDF bill that Mr. Cooper introduced last year, there is created there a national health care board that is the most powerful Federal regulatory I have ever seen in a proposed statute. I am not saying that is wrong, but I am saying this is not a pure private sector undertaking. There is an enormous Federal regulatory role in those proposals.

Mr. GRANDY. I would point out that just—I am not defending the Iamater project. Most people agree there should be some kind of Federal regulatory agency that presides over the private sector regulation and probably does dictate what the basic health care benefit is beyond which you would probably have to pay additional premiums.

I don't want to suggest that government is completely divorced from any model we are talking about. Nobody is advocating that. It is the question of whether regulations are proposed.

Dr. LEE. The commission is doing an analysis of managed competition and the marriage of managed competition with expenditure limits. The staff has done an initial paper, which is being further developed through discussion with the commission. I would say it is a question of whether you regulate the provider or whether you regulate the plan.

And there will be a regulatory apparatus, as you have indicated, both with the national board and certainly at the State level in a State the size of California if you authorize it. With the HIPCs, there would have to be some regulatory structure to make sure that they are performing their functions properly, because you would give not only major authority to regulate these plans, but also with respect to quality assurance, with respect to informing the consumer. And the data requirements, as Bruce indicated, are serious problems.

The other factor that has to be overcome is risk adjustment so that you don't have this kind of skimming of the healthy populations when you have a community rated standard benefit package. You then have to be able to risk adjust. And the methodology for that is certainly not sufficiently developed to make this something you could implement quickly in terms of national policy.

Mr. GRANDY. Mr. Chairman, if I could just followup for one question.

I just—you said measuring quality assurance and Dr. Vladeck said that the data that we are generating may keep us 15 years away from really being able to do that. How do you then implement a managed care competition with the Government overseeing all of these plans, supposedly distributed and managed by HIPCs with Federal oversight, if there is no real way to determine quality assurance?

Or did I misunderstand you Dr. Vladeck?

Mr. VLADECK. Well, I would distinguish between using data to measure quality where I think we are some time away, and expecting providers of service to undertake quality assurance activity, which we do—which we have been doing for years with hospitals and other providers with mixed results.

You can expect a managed care plan to have certain quality assurance mechanisms that will protect consumers. And I think we have made a lot of progress in developing those, and it is not hard comparatively to develop more, but if the notion is that you can pick up Consumer Reports, which will list every general internist in your community, or even the four or five plans each on 8 or 10 dimensions, and give you a score from 1 to 5 on their quality ratings based on some methodologically defensive, scientifically defensible methodology, I think we are several decades away from that.

Dr. LEE. Coming from California where there is much more developed managed care in place, Kaiser Permanente being one of the main ones, we have very innovative developments in this prepaid area. Organizations like Healthnet, for example, have developed some very innovative approaches to quality assurance within

competing systems, and I think this committee needs to take a very careful look.

There is much more going on out there than has been reported in the literature and I would perhaps disagree with Bruce a little bit on the timeframe in terms of the data developments required. Developments, things like profiling, outcome measures, clearly need to be more rapidly developed, but there is a lot of experience now in managed care.

We haven't seen the kind of cost savings that were touted for that in the 1980s. Whether we can achieve those with the kind of proposals that Alain Enthoven is now making, and others, remains to be seen. And we need to really analyze, in terms of what the potential is for those kinds of systems to really function in terms of cost themes.

Theoretically, it makes a great deal of sense, and from my standpoint in terms of the potential for quality of care, it makes a great deal of sense, but we have yet to really prove that. The Calper's experience, which I know you are familiar with, is another example that might merit much more detailed examination by this committee.

Mr. GRANDY. Thank you. Mr. Chairman, thanks for the extra time.

Chairman STARK. I want to thank the staff. And I want to point out to my colleague from Iowa, the best thing about having a Federal board to help us implement health care policy is before you as we speak. I want to thank the distinguished members of both of the panels for informing us today.

We will continue with testimony from three experts. We will have Dallas Salisbury, who is the president of the Employee Benefit Research Institute; Katherine Swartz, who is associate professor of the School of Public Health at Harvard University, and E. Richard Brown, who is professor of the School of Public Health at the University of California, Los Angeles.

We would like to welcome the panelists to the committee, and your prepared testimony will appear in the record in its entirety. We would ask that you summarize or expand on your testimony to the committee in any manner that you feel comfortable, and we will ask Mr. Salisbury if he would like to lead off.

STATEMENT OF DALLAS L. SALISBURY, PRESIDENT, EMPLOYEE BENEFIT RESEARCH INSTITUTE

Mr. SALISBURY. Congressman Stark, it is a pleasure to be here. With the amount of detail and information already covered, it may leave all of us with a bit of a feeling of what is there left, but there is at least a little bit.

Knowing that the full statement that I have provided will be included in the record and moving on from some of what has already been discussed, there are a few points that I would emphasize.

First, related to the issue that has arisen on coverage and whether or not coverage has increased or decreased. In the special report that we submitted to the committee, looking at the March 1992 Current Population Survey, I would simply note that the proportionate individuals in the population with employment-based

health insurance coverage was at a level of 75 percent in 1988, and by the March 1992 survey had declined to 72.3 percent.

I would note that where there has been an offsetting increase in coverage it is as a result of publicly sponsored coverage, particularly Medicaid where we have seen those with Medicaid increase from 1988 at 8.6 to 11 percent in March 1992.

The aggregate coverage percentage in the population has stayed roughly at 16 percent of the population, but I underline we have seen this shifting with an increasing role for Medicaid and a slight decline in employment-based protection.

As the tables submitted to the committee indicate, most of that decline in employment-based coverage has been in the small employer sector where there continue to be problems in terms of the acquisition of insurance, and the risk characteristics in that marketplace.

We have also tried to look at actions over a 4-year period with public opinion surveys in this area. We find that provision of health insurance and the growth of it does go at least a bit beyond the statement of the prior panel, which attributed it almost entirely to the fact that tax preferences are provided to health care coverage.

I simply underline that consistently employees view health insurance next to cash wages as the employee benefit they would prefer, and as documented in the testimony, they state over the years a consistent preference for that health protection coming through the place of employment as compared to other alternatives. For example, between a preference for doing it on their own, that is only stated by 14 percent of the population.

I would emphasize and underline that as Nancy Gordon said, that it is principally in the very small employer setting where we have a tremendous number of uninsured individuals accounting with 25 or fewer employees for fully 45 percent of the uninsured population in America. As well, there is tremendous concentration, as her testimony noted, in the low-income population with 54 percent of the uninsured also in families with annual incomes below \$20,000 per year, compared to only 11 percent in families with \$20,000 or more.

We further, in this testimony, attempted to look at the issue of some of the proposals for taxation and the degree to which that might impact behavior. We included it more because of the assumed discussion and what we frequently read in the analyses that implies that the taxation of health insurance benefits would be a very progressive type of proposal. And it is more—we have provided this testimony to have individuals focus on the economic impact as decisionmaking that is going forward, but, to provide a brief example, if one takes an individual working for the House of Representatives earning \$100,000 per year, and a second individual working for the House of Representatives earning \$20,000 per year, and based on a tax cap, one were to assume the production of \$1,000 in new taxable income as a result of a tax cap, the \$100,000 individual would see their tax bill increase by \$400, or four-tenths of 1 percent of their income; whereas that \$20,000 employee would see their tax bill increase by \$200, or fully 1 percent of their income.

In fact, it is a regressive effect relative to total income and total taxes paid, even though the higher income individual pays more in absolute dollars.

Chairman STARK. Just in terms of what you know about employee benefits, can any of you guess as to whether that would have any bearing on a person's choices? It seems to me that that is pretty elastic.

Mr. SALISBURY. I think you are likely to see, Congressman Stark, that it would have almost no impact on the high-income individual's decisionmaking and a potentially significant impact on the lowest income individual's decisionmaking.

Chairman STARK. Thank you.

Mr. SALISBURY. Finally, we looked in the testimony at some of the implications, employment and otherwise, at some of the proposals for change. I won't go into those due to time.

I would like to conclude, given the last comments and questioning of the Congressman from Iowa, with a comment on the issue of Cincinnati and Iamater, just so that the record is clear, as I was at the same meeting with Dr. Vladeck and Dr. Lee and would note that I was also the individual at the meeting who made reference to the Iamater project.

So to make the record clear, the conversation went as follows: I noted that Dr. Enthoven had found his example of managed competition, and in meetings was saying that his found example was Cincinnati, and that his example was the Iamater project with the 14 hospitals, et cetera. And I made a comment that as Iamater was now moving that to be a network that would be available after January 1, 1994, that there were some 90 significant employers in Cincinnati that had said they would be interested in using that network, potentially along with others.

At the meeting also was a representative of General Electric Corp., which is one of the four large Cincinnati employers involved in the Iamater project, but not an individual, I would note, from Cincinnati. That individual made the following two comments: One, they would not be interested in exclusively using the Iamater network; that they would use that as well as other available networks, and that they did not view it as the singular answer, but then he added what I think is a significant comment, that what was happening in Cincinnati was indeed special; that they had found through the development of data and managed care systems there that General Electric was realizing among the smallest rates of medical increases in the Cincinnati marketplace as compared to all other markets in which they provide health insurance benefits.

So he made note of, A, that Iamater might not be the be-all and the end-all, but the overall focus on data and managed care moving into the Cincinnati marketplace was clearly making a difference in the inflation rate in medical care.

Thank you, Mr. Chairman.

[The prepared statement follows:]

**Statement of Dallas L. Salisbury, President,
Employee Benefit Research Institute**

I am pleased to appear before you today to discuss current trends in health insurance coverage. My name is Dallas Salisbury. I am the president of the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has long been committed to the accurate statistical analysis of public policy benefits issues. Through our research, we strive to contribute to the formulation of effective and responsible health, welfare, and retirement policies. In keeping with EBRI's mission of providing objective and impartial analysis, our work does not contain recommendations.

◆ **Introduction**

The number of Americans without health insurance and with reduced access to health insurance represents a longstanding public policy issue. Many policymakers have sought to expand access by reforming the health care delivery system. This testimony provides information about public attitudes on health care, the current sources of health insurance in the United States, and the characteristics of the insured and uninsured to help in evaluating and estimating costs of health care reform proposals.

In addition, EBRI has estimated the impact of various reform proposals and examined how they would affect the coverage, costs, and quality of health care. This testimony examines the impact of limiting the tax exclusion for employer contributions to health insurance from workers' taxable income. It also examines the potential impact of employer mandates on the number of uninsured and on employment.

◆ **Public Attitudes on Health Care**

The public will be the arbiter of whether or not health reform initiatives are focused properly. To assess the shifting tides of public opinion, EBRI and The Gallup Organization, Inc. have conducted a monthly series of national public opinion polls on public attitudes toward economic security issues such as health insurance, health care satisfaction, and the value of benefits since June 1989. As elected officials well know, the tide of opinion can shift rapidly and a move from "what do you want?" to "what are you willing to pay?" can produce very different results.

Our surveys indicate that obtaining health insurance is a top priority for most Americans. A 1992 EBRI/Gallup poll found that 68 percent of Americans regard health insurance as their most important employee benefit, compared with 61 percent in 1990; 56 percent said they would not accept a job that did not provide health benefits. Respondents said that their employer would have to pay them an average of \$4,570 in additional income to forgo their current employer-provided health benefits. This compares with \$4,219 in 1990. Individuals prefer the hidden costs of lower wages over direct payments like premium co-payments.

Not only do Americans value the provision of insurance, the majority are satisfied with the health care they receive. However, they are not satisfied with the U.S. health care system as a whole. A 1992 EBRI/Gallup poll found that while more than 7 out of 10 Americans (73 percent) rate the U.S. health system as fair or poor (compared with 66 percent in 1990), most of those who indicated they had received care from a doctor or hospital in the past year rated the quality of that care as excellent or good (83 percent).

In response to a 1991 EBRI/Gallup survey, when asked what they liked most about the overall quality of the care they received from their physicians, respondents cited factors that are synonymous with higher cost such as attention and care (12 percent), friendliness (11 percent), and availability (10 percent). When asked what they liked least about their care, no single factor received special emphasis, but they were factors that generally reduce cost, including waiting time (8 percent); insufficient time spent by physician with patient (6 percent); and limited availability (4 percent). In addition to giving high ratings to their personal health care, respondents also expressed satisfaction with their health insurance benefits.

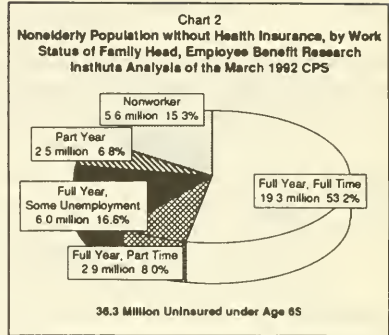
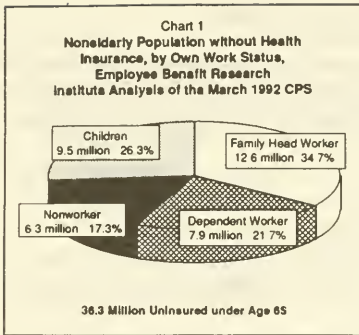
These findings suggest that the satisfaction that insured Americans feel for their health care may reduce their willingness to accept reform proposals that may alter or ration the care they receive.

Several 1992 EBRI/Gallup surveys explored public attitudes toward policy options for health care reform. These surveys indicate a preference for employment-based insurance versus government provision. Forty-eight percent of respondents felt that employers should be most responsible for providing health benefits to full-time employees and their dependents rather than the federal government (31 percent) or individuals themselves (14 percent).

While Americans tend to indicate a preference for an employment-based system, there continues to be support for other options for reform (such as government-sponsored national health insurance). However, while there is widespread support for various reform options, surveys indicate that most Americans have not yet come to terms with the various tradeoffs inherent in each option for reform—particularly with regard to cost.

For example, most analysts agree that access to health care cannot be increased without increasing costs or placing some limits on the care received. Yet, 77 percent of Americans said they believe everyone should receive the same amount and quality of health care, whether or not they can pay for the care, and 86 percent said they either disagree (47 percent) or strongly disagree (39 percent) that it would be acceptable to reduce the amount of health care available to the elderly in order to slow the rise in health care costs and increase access to health care for all Americans. In addition, a majority of Americans also disagreed or strongly disagreed with limiting the types of services public health programs will pay for low-income individuals (66 percent), the types of services health insurance plans will pay for (61 percent), and the introduction of new, more expensive high technology equipment that saves lives but may increase costs (57 percent). Despite this unwillingness to limit care, almost 8 out of 10 Americans (79 percent) indicated that the biggest problem in health care for society as a whole is cost.

The views expressed in this statement are solely those of the author and should not be attributed to the Employee Benefit Research Institute, its officers, trustees, sponsors, or other staff. The Employee Benefit Research Institute is a nonprofit, nonpartisan, public policy research organization.



◆ Access to Health Insurance

More than 180 million persons under age 65—representing 83 percent of that population—were covered by either private or publicly financed health insurance in 1991.¹ Although some of the nonelderly had public health insurance (15 percent), the most common source of coverage was private insurance—usually purchased through an employment-based plan. However, 16.6 percent of the nonelderly population—or 36.3 million people—received neither private health insurance nor publicly financed health coverage.

Some uninsured individuals have limited access to basic health care services partly because they lack private health insurance and are ineligible for (or do not otherwise receive) publicly financed health care. Uninsured individuals may be forced to seek medical care for preventable ailments that could have been treated less expensively if they had received access to preventive health services. The cost of inefficient, uncompensated care is borne by all payers in the health care delivery system. The American Hospital Association estimated that hospitals provide \$10 billion in uncompensated care annually.² Another study estimated that uninsured patients accounted for 11 percent of personal health care expenditures in 1988 (\$32 billion), even though they had 37 percent fewer physician contacts and 69 percent fewer inpatient days.³ The money spent annually on inappropriate care for uninsured patients may be more effectively spent by expanding access to basic health care services.

The March Current Population Survey (CPS) provides an important source of information about the economic and health insurance status of the U.S. population.⁴ The following discussion and tables are based on the March 1992 CPS. This survey focuses primarily on the nonelderly population because this group receives health insurance coverage from a number of different sources, depending on income, employment status, and location, and because 96 percent of Americans aged 65 and over have Medicare coverage. This information can be useful in the analysis of legislative proposals designed to expand access to health care services.

Among the 36.3 million nonelderly Americans who did not have health insurance coverage in 1991, most were working adults (56.4 percent), while the remainder were children (26.3 percent) and nonworking adults (17.3 percent) (chart 1). The total number of uninsured under age 65 increased from 33.6 million in 1988 to 36.3 million in 1991.

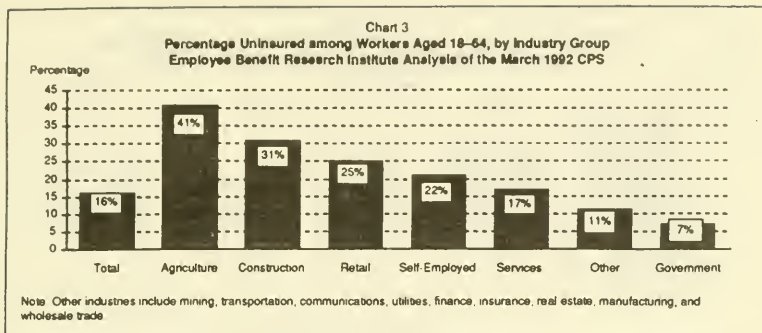
Although some of this increase can be attributed to population growth, the percentage reporting no health insurance coverage has also increased from 15.9 percent to 16.6 percent between 1988 and 1991. However, there was no significant change in the percentage of the nonelderly population without health insurance between 1990 and 1991.

Employment Status

The most important determinant of health insurance coverage is employment. Nearly two-thirds of the nonelderly have employment-based coverage. Employers purchasing group health insurance are often able to obtain less expensive policies because insurance companies can spread the risk across a larger group of people. The nature of employment, the industry, and the size of the firm often determine the cost and extent of coverage. Workers in large firms are more likely to be covered than seasonal or part-time workers.

In 1991, 85 percent of the uninsured were working or living in a family headed by workers, primarily because most people live in families headed by workers (chart 2). More than 60 percent of the uninsured were in families headed by full-year workers with no unemployment; 53 percent were in families headed by full-year, full-time workers, and 8 percent lived in families headed by full-year, part-time workers. Even though only 12.6 percent of individuals in families headed by a full-time, full-year worker were not covered by insurance, they represent the largest segment of the uninsured (53 percent). However, individuals in families headed by a part-time worker were more likely to be uninsured than those headed by full-time workers. Individuals in families whose family head worked fewer than 17 hours per week were less likely to be uninsured (26 percent) than individuals in families whose family head worked between 17 hours and 34 hours per week (31 percent). This may be because publicly financed health coverage is less available to the latter group.

Industry—The majority of uninsured workers reported their industry of primary employment was retail trade, services, or manufacturing (chart 3)—industries that employ a majority of the work force. Workers most likely to be uninsured were either self-employed or working in agriculture, construction, retail sales, or services. Agricultural workers may be



migratory and/or be paid low hourly wages. Construction industry workers may be employed on a contractual basis for a particular project. Because workers in these industries may not work consistently for the same employer, they are less likely to have employer-sponsored health insurance. Workers in the retail sales and service industries, which employ many part-time workers and experience rapid turnover, are often subject to waiting periods before becoming eligible for benefits.

Firm Size—Nearly one-half of all uninsured workers were either self-employed or working in firms with fewer than 25 employees in 1991 (chart 4). Twenty-two percent of self-employed persons were uninsured, compared with 17 percent of all workers. Thirty-two percent of workers in firms with fewer than 10 employees were uninsured, compared with only 9 percent of workers in firms with 1,000 or more employees. Small employers often are unable to obtain reasonably priced health insurance for their employees because insurers generally charge them higher premiums due to the greater risk posed by a small group. In 1991, although only 27 percent of the nonelderly population lived in families whose head of household was self-employed or worked for a firm with fewer than 25 employees, this group accounted for 45 percent of the uninsured.

Income

The uninsured are concentrated disproportionately in low-income families. In 1991, 54 percent of the uninsured were in families with annual incomes under \$20,000 (table 1). While 34 percent of all individuals in families with incomes of less than \$5,000 were uninsured, only 11 percent of all individuals in families with incomes of \$20,000 or more were uninsured. Families with incomes below the federal poverty level were more likely to be covered by publicly financed health programs or be uninsured than to be covered by private insurance. As income increases, the percentage of the population without health insurance and the percentage covered by publicly financed programs decrease, while the percentage covered by private health insurance increases. Because eligibility levels for Medicaid, the primary publicly financed health program for the nonelderly, are cut off at certain income levels (rather than being phased out),⁵ the percentage uninsured among families with incomes below the poverty level was slightly less than that among families with incomes just above this level. This situation occurs because families with incomes just above the poverty level are less likely to be eligible for publicly financed insurance. At the same time, these people are also less likely than those with higher incomes to receive employer-sponsored health insurance.

Workers with low earnings are more likely to be uninsured than those with high earnings (chart 5). Thirty-one percent of workers with earnings below \$10,000 were uninsured, compared with only 3 percent of workers with earnings of \$50,000 or more. This is primarily because low-income workers tend to be employed in industries that are less likely to offer health insurance and/or have a weaker or temporary attachment to the work force. These workers may also be employed only part time or unemployed at times.

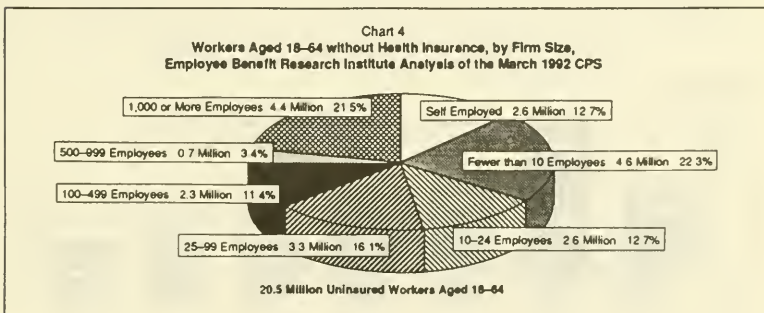


Table 1
Nonelderly Population with Selected Sources of Health Insurance, by Family Income,
Employee Benefit Research Institute Analysis of the March 1992 CPS

Family Income	Employer Coverage						Total Public	Medicaid	No Health Insurance Coverage
	Total	Total Private							
			Total	Direct	Indirect				
(millions)									
Total	218.1	157.7	139.8	70.3	69.6	18.0	31.7	23.9	36.3
Under \$5,000	12.9	2.1	0.8	0.4	0.4	1.2	6.7	6.4	4.4
\$5,000-\$9,999	15.9	3.3	2.0	1.3	0.7	1.3	8.1	7.4	5.1
\$10,000-\$14,999	16.1	6.7	5.2	3.2	2.0	1.4	4.6	3.9	5.6
\$15,000-\$19,999	15.7	9.1	7.6	4.4	3.2	1.4	2.7	2.1	4.7
\$20,000-\$29,999	32.6	23.8	21.0	11.4	9.6	2.9	3.5	2.3	6.6
\$30,000-\$39,999	30.6	25.9	23.6	11.4	12.2	2.3	1.8	0.8	3.8
\$40,000-\$49,999	26.4	23.5	21.7	10.0	11.6	1.9	1.4	0.4	2.4
\$50,000 or More	67.9	63.4	57.9	28.2	29.7	5.5	2.9	0.6	3.8
(percentage within coverage categories)									
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under \$5,000	5.9	1.3	0.6	0.5	0.6	6.9	21.3	27.0	12.0
\$5,000-\$9,999	7.3	2.1	1.4	1.8	1.0	7.3	25.5	31.1	14.0
\$10,000-\$14,999	7.4	4.2	3.8	4.5	2.9	8.0	14.4	16.2	15.4
\$15,000-\$19,999	7.2	5.7	5.5	6.3	4.6	7.9	8.4	8.6	12.8
\$20,000-\$29,999	15.0	15.1	15.0	16.2	13.8	16.1	11.2	9.5	18.2
\$30,000-\$39,999	14.0	16.4	16.9	16.3	17.5	12.6	5.8	3.2	10.5
\$40,000-\$49,999	12.1	14.9	15.5	14.3	16.7	10.5	4.3	1.9	6.6
\$50,000 or More	31.1	40.2	41.4	40.1	42.7	30.7	9.1	2.6	10.5
(percentage within income categories)									
Total	100.0%	72.3%	64.1%	32.2%	31.9%	8.2%	14.5%	11.0%	16.6%
Under \$5,000	100.0	15.9	6.3	3.0	3.3	9.6	52.3	49.9	33.9
\$5,000-\$9,999	100.0	20.8	12.5	7.9	4.6	8.3	31.0	47.0	32.2
\$10,000-\$14,999	100.0	41.4	32.6	19.9	12.8	8.9	28.5	24.2	34.7
\$15,000-\$19,999	100.0	57.7	48.6	28.1	20.5	9.1	17.0	13.1	29.6
\$20,000-\$29,999	100.0	73.0	64.3	34.8	29.5	8.8	10.9	6.9	20.2
\$30,000-\$39,999	100.0	84.6	77.2	37.3	39.9	7.4	6.0	2.5	12.5
\$40,000-\$49,999	100.0	89.2	82.1	38.1	44.0	7.2	5.2	1.7	9.0
\$50,000 or More	100.0	93.3	85.2	41.5	43.8	8.1	4.2	0.9	5.6

Note: Details may not add to totals because individuals may receive coverage from more than one source.

Family Type

Single individuals and individuals in single parent families were more likely to be uninsured than married couples either with or without children (chart 6). Married couples and two parent families may have higher levels of income and both adults may be employed, increasing their chances of receiving employment-based coverage and, if not covered through an employer, they may be more able to afford individually purchased private health insurance. Among poor and near-poor families (up to 124 percent of the poverty level), both married (46 percent) and single individuals (47 percent) without children were more likely to be uninsured than other family types. Families with children were less likely to be uninsured, at least in part because they were more likely to be receiving publicly financed health coverage. Sixty-seven percent of individuals in low income single parent families were covered by Medicaid in 1991, compared with only 27 percent and 31 percent of low income married couples and single individuals without children, respectively, and 37 percent of low income individuals in two parent families. Therefore, even though members of low-income two parent families were more likely to be covered by private health insurance than members of low-income single parent families (32 percent, compared with 15 percent), they were more likely to be uninsured (36 percent compared with 21 percent).

Chart 5
Percentage Uninsured among Workers Aged 18-64, by Total Earnings,
Employee Benefit Research Institute Analysis of the March 1992 CPS

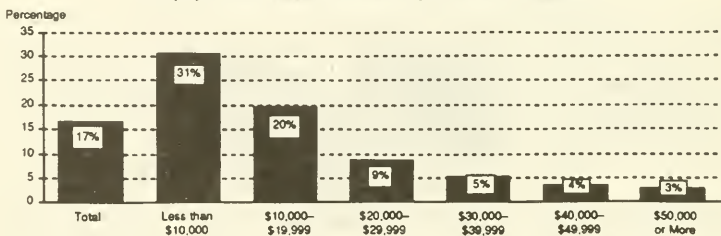
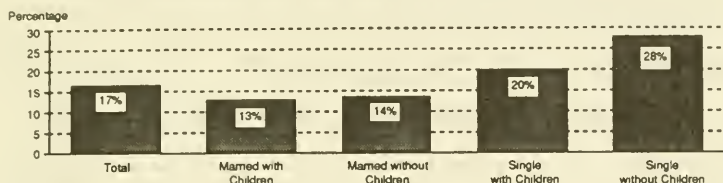


Chart 6
Percentage Uninsured among the Nonelderly Population, by Family Type,
Employee Benefit Research Institute Analysis of the March 1992 CPS



Other Demographic Characteristics

Sex and Age—Men were more likely to be uninsured than women in all age groups except between ages 55–64. Women were generally less likely than men to be covered directly by an employer health insurance plan but were more likely to receive employer coverage as dependents of other workers and publicly financed health coverage.

Individuals aged 45–64 were less likely to be uninsured (12 percent), and individuals aged 21–24 were more likely to be uninsured (30 percent) than those in all other age groups in 1991 (chart 7). The high proportion of young adults without health insurance may be because they are no longer covered by a family policy and have not established themselves as permanent members of the work force. In addition, many in this group may think that they do not need health insurance because they are young and healthy. Finally, young workers may be ineligible for an employer-sponsored plan because of waiting periods imposed prior to eligibility.

◆ Health Care Reform Proposals

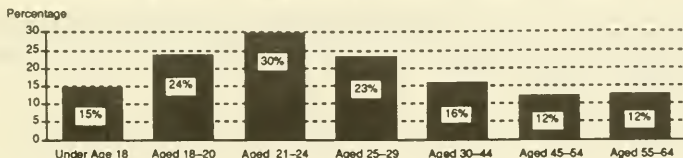
Congressional proposals for health care reform occupy almost every point along the spectrum from essentially fine tuning the health care delivery system by changing tax or regulatory policy to abandoning the private market and adopting a national health care delivery system. Recent policy attention has focused on proposals to limit the exclusion of employer contributions to health insurance and to mandate the provision of employer-sponsored coverage. EBRI has estimated the impact of such proposals.⁶

Tax-Based Reform

Several policymakers have recently suggested limiting the exclusion of employer contributions to health insurance from workers' taxable income. Advocates assume that if contributions are limited to a maximum dollar amount or to the average cost of a basic health plan in a geographic area, employers and employees would be more likely to choose cost-effective providers. Using the Tax Estimation and Analysis Model (TEAM), EBRI estimated the impact of capping tax-exempt employer contributions to health plans at \$2,940 for family coverage and \$1,080 for individual coverage. For those filers with employer-sponsored health benefits the imposition of a tax cap would be regressive in the sense that lower income filers would pay a larger percentage of their income than higher income filers toward the new tax.

Along with shifting the distribution of the tax burden, capping the tax exemption of employer contributions to qualified health plans would also generate additional federal revenue. EBRI's estimates assume no change in individual or employer behavior, although it is expected that significant behavioral change would occur as a result of changing the tax treatment of health benefits. These estimates should be considered as the maximum revenue that could be raised because they were produced assuming no change in behavior. According to our estimates, most of the tax revenue raised would come from middle and upper-middle income tax payers, with \$8.3 billion coming from taxpayers with annual incomes of \$20,000–\$50,000 and \$5.7 billion coming from taxpayers with annual incomes of \$50,000–\$100,000. This compares with \$2.6 billion in revenue from taxpayers with annual incomes of less than \$20,000 and \$2.1 billion from taxpayers who earn more than \$100,000 annually. EBRI also used TEAM to estimate the federal revenue raised as a result of an annual cap of \$6,000 for family coverage and \$2,400 for individual coverage. Most revenue would again be generated by taxing those with annual incomes between \$20,000 and \$50,000 (\$2.8 billion), followed by taxpayers with annual income between \$50,000 and \$100,000 (\$1.5 billion).

Chart 7
Percentage Uninsured among the Nonelderly Population, by Age,
Employee Benefit Research Institute Analysis of the March 1992 CPS



Employer Mandates

Proposals to require all employers to provide health benefits to their workers have been offered in Congress for over three decades. Renewed attention has focused on an employer mandate coupled with tax changes and insurance reforms. Employer mandates vary according to the employers that are required to participate, classes of employees covered, and length of time allowed to comply with provisions.

EBRI simulated the effects of an illustrative employer mandate, assuming that employers would be required to offer health benefits to all employees who worked more than 19 hours or 25 hours a week.

There are three critical assumptions that analysts have to make to estimate the impact of imposing a mandate: 1) how do wages and other benefits adjust when health insurance is required to be an element in total compensation; 2) how sensitive to changes in the costs of labor is employer demand for workers; and 3) how much would a mandated health plan cost. EBRI assumed that wages and other benefits did not adjust in estimating the number of individuals who would lose their jobs as a consequence of a mandate that employers provide health benefits to their employees.

Requiring all employers to provide health benefits to workers and their dependents would decrease the number of uninsured from 36 million to 10 million, according to EBRI estimates. Because many of the uninsured work for small firms, exempting employers with fewer than 25 employees would only reduce the number of uninsured to about 25 million. This analysis assumes that there are no changes in employment as a result of a mandate, even though health benefits represent a significant component of total compensation (10.9 percent of payroll among employers who offer health benefits⁷). Clearly, if a mandate were implemented without a transition period, that would allow other elements of total compensation (such as wages) to adjust, the cost of labor would increase substantially, possibly causing some job loss.

EBRI simulated changes in employment that would occur as a result of mandating that all employers offer health benefits (wages and other elements of total compensation were held constant). The sensitivity of employer demand for workers to changes in the price of labor is crucial in this simulation. The EBRI analysis used a range of estimates of this sensitivity based on economic literature.⁸ It should be noted that other values supported by the economic literature could be cited that would increase or decrease the estimated employment effects by large amounts. The other crucial assumption used in this simulation was the costs of the mandated health benefits. Without specifying the actual component services that would be covered, separate EBRI simulations were conducted using different estimates of the average annual cost of health benefits per individual employee: \$970, \$1,450, and \$2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost. Again, these estimates assume that wages and other benefits do not change as health benefits are added. Clearly, if wages adjust, fewer individuals would become unemployed as a result of a mandate.

EBRI's simulations estimated that between 200,000 and 1.2 million workers could become unemployed as a direct result of a mandate that employers provide health benefits to their employees. The higher estimates were the result of higher average costs of the mandated health plan and greater price sensitivity of the demand for labor.

The range in the estimates of the number of people who would lose their jobs as a result of mandates comes from the various combinations of benefit costs and sensitivity in the demand for labor to changes in costs. The estimate of 1.2 million for example can only be reached by assuming that employers are very sensitive to costs of labor and the health benefit package is very expensive. As is apparent, the estimates of job loss (and of the total costs of the policy) are extremely sensitive to the assumptions used in the simulation.

EBRI analysis also found that the cost of an employer mandate would be borne primarily by small employers and their employees. EBRI estimated that an illustrative employer mandate would increase spending by employers on employer-sponsored health benefits by \$33 billion to \$86 billion. The wide range between the estimates is related to assumptions about health plan costs. If employers with fewer than 25 employees were exempt from the mandate, spending would increase by \$12 billion to \$33 billion. Costs for employer-sponsored health benefits would also be redistributed. Workers who had previously been covered under another employer's plan would now be covered directly under their own employer's plan. For example, under a mandate with an average health plan cost of \$1,450 per individual employee and no employer size exemptions, about \$20 billion in costs would be redistributed from one employer to another. About 45 percent of these transferred costs (\$9 billion) would be redistributed to small employers. If small employers were exempt from the mandate, the total costs redistributed among all employers would be only about \$5 billion.

The ultimate aim of these simulations is to understand who will bear the costs of expanding health insurance coverage through mandating that employers provide it to their employees. Other analysts have estimated a much smaller increase in the number of individuals who may lose their jobs because of an employer mandate by assuming the wages and other benefits would fall enough to fully account for the cost of the mandated plan. Regardless of what assumptions are used, it is clear that the recipient of the coverage will inevitably bear the costs of the coverage, either through loss of his or her job or lower wages and other benefits. Arguments have been advanced on both sides of the issue of whether this is a fair, equitable, or efficient result.

The question of whether uninsured workers and their families would be better off if health insurance were extended to them under a mandate centers on the issue of whether they are uninsured by choice. Do workers select jobs that do not offer health benefits in order to receive higher levels of cash compensation or other benefits? If employees are choosing a total compensation package that does not include health benefits, any measure that forces them to accept a package with health benefits will make them worse off.

However, society may benefit by forcing individuals to purchase health insurance. Individuals who choose to not purchase health benefits are gambling that they will not need health care services. They may make that bet knowing

that care will be available to them in the case of a catastrophic event. Thus, society may bear at least a part of the risk that the individual chose not to insure against.

An employer mandate is essentially a payroll tax, although the burden of that tax is not distributed equally across all employees, employers, or consumers. Some of the costs of mandated health benefits would be passed on to employees in the form of lower wages, lower levels of other noncash benefits, or unemployment. Low-income workers would have less opportunity to trade wages for health benefits and would be more likely to experience the effects of an employer mandate in the form of unemployment. Some of the costs might be passed on to consumers in the form of higher prices. The remainder of the costs of a mandate would be borne by the investors and owners of the firms subject to the mandate. The distribution of this burden would vary by industry, region, firm size, and ownership type. The ultimate incidence of this tax will be determined by the market for health insurance.

◆ Conclusions

The majority of Americans consider health care to be a right. Although most prefer care with no cost, they are willing to share some costs explicitly and more costs on a hidden basis. Americans want "reform", but only reform that means more attentive providers, more accessibility, no risk of forfeiture, and lower costs.

This testimony provides information on the characteristics of Americans with and without health insurance that should be useful in analyzing health care reform proposals as the new administration prepares its agenda for health care reform. More detailed data can be found in EBRI's January 1993 *Issue Brief*, "Sources of Health Insurance and Characteristics of the Uninsured," which we have provided to the Subcommittee.

EBRI's estimates of tax changes and employer mandates attempt to draw out some of the tradeoffs implicit in health care reform. As this testimony illustrates, there are limits in determining the effects of these proposals. Important details of many of the proposals have not been developed. Moreover, the literature on important questions such as the effects of tax changes and increased labor costs is often incomplete or contradictory. The greater the amount of change proposed by a reform proposal the greater the uncertainty of estimates regarding costs and coverage.

◆ Endnotes

¹These data are taken primarily from an EBRI *Special Report/ Issue Brief*, "Sources of Health Insurance and Characteristics of the Uninsured," January 1993.

²American Hospital Association. Statement of the American Hospital Association Before the Committee on Ways and Means of the U.S. Congress, House of Representatives, on National Health Care Reform. October 10, 1991: Summary. Washington, DC: American Hospital Association, 1991.

³Lewin/ICF. *The Health Care Financing System and the Uninsured*. Prepared for U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Lewin/ICF, 1990.

⁴The March CPS questions individuals about their health insurance coverage throughout the preceding calendar year. Respondents to the 1992 survey were instructed to provide information about their health insurance coverage during 1991. Assuming accurate responses were given, the uninsured should include only those individuals who were without health insurance for the entire 12 months. However, a comparison of the results of the March 1990 survey with the Survey of Income and Program Participation has led some researchers to believe that many respondents actually answer the health insurance questions with reference to either a particular point in time or to some period of time less than the full year.

⁵Medicaid eligibility levels are set by individual states and vary from 13 percent of the federal poverty rate in Alabama to 77 percent in Alaska. About two-thirds of the states have higher income eligibility thresholds for "medically needy" persons. All states are required to provide Medicaid coverage to pregnant women and children up to age 6 if their income is less than 133 percent of the federal poverty level. In addition, states must cover children born after September 30, 1983, in families with income below the poverty level.

⁶A more complete examination of EBRI's analysis of various health care reform proposals can be found in EBRI's *Issue Brief*, "Health Care Reform: Tradeoffs and Implications," April 1992.

⁷A. Foster Higgins & Co., Inc. *Health Care Benefits Survey, Report 1: Indemnity Plans*. New York: A. Foster Higgins & Co., Inc. 1992.

⁸Hamermesh, Daniel S. "The Demand for Labor in the Long Run." In *Handbook of Labor Economics*. Vol. 1. New York: Elsevier Science Publishers, 1986.

Chairman STARK. The record will show that.

I am going to have to excuse myself for a few minutes, and Mr. Andrews will chair. But I would like to just leave this question for later, and perhaps you can address it, after the other two witnesses.

There has been some suggestion, and I am sure I don't recall where, that one of the ways to save some money in the Medicare system is to extend the age at which you qualify from 65 perhaps to 67. It concerns me that we might then leave people uninsured and pass that burden on to industry, which is already struggling with uninsured retirees. I am concerned that unless somehow we could boost the retirement age, we might be causing a bigger problem than we would solve.

And I won't ask you to comment now, but the committee might want to reflect on that, because I think this panel of witnesses might be uniquely qualified to testify a little bit on the problems we might be creating if we followed that.

[The following response was subsequently received:]

Mr. Chairman, you are directly on point to worry about the consequences of a change in the age of Medicare eligibility. Among individuals over the age of 40, fewer than 40 percent have any promise of retiree medical benefits. If anything, the number is declining as employers deal with rising health care costs.

The health care continuation provisions of COBRA would guarantee individuals the ability to maintain health insurance for 18 months after the date of retirement, but with the individual paying the full premium. In the absence of health insurance reform providing for flat community rating, these individuals could be charged an age rated premium that could render the coverage unaffordable. At EBRI this would be over \$12,000 per year for a 65-year-old couple under our managed care policy.

Only if the intent of the Medicare age change was to, in effect, force individuals to work longer would it make any sense. Given present aging trends this might be good policy, but only if the jobs are available.

Chairman STARK. I am trying to see who is next on the list.
Dr. Swartz.

**STATEMENT OF KATHERINE SWARTZ, ASSOCIATE PROFESSOR,
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HAR-
VARD SCHOOL OF PUBLIC HEALTH, BOSTON, MASS.**

Ms. SWARTZ. Thank you, Mr. Chairman, for inviting me to speak on what I believe is one of the most pressing issues in health care reform today: the roughly 35 million Americans who did not have health insurance as of last March.

This estimate of 35 million reflects an increase of almost 4 million people since 1988. In summarizing my written statement, I want to make two points this morning.

First, the increase in the number of Americans without health insurance is partially due to the economic recession, but it is also due to current industry trends that are taking the insurance out of health insurance: Trends that place far more than 35 million Americans at risk for not having their health care cost covered.

And, secondly, the people without health insurance are not all alike in terms of their incomes and other characteristics, nor in terms of the length of time that they spent without health insurance.

Our current system of health insurance is moving toward a world in which only the young and healthy will have insurance. As you know, most health insurance companies set premiums using experience rating rather than community rating. Experience rating encourages insurance companies to do as much as possible to separate low-risk individuals from high-risk individuals, and to set premiums accordingly.

If a person purchases health insurance through an employer group, the premium is based on a composite profile of the health risks of the group's members. So if an employee works for a employer that has very young work force for that employee's premium is far lower than his neighbor who may work and do exactly the same kind of work, but works for an employer that has an older work force.

The increasing sophistication of computerized insurance records now permits the insurance companies to examine the flows of expenditures made on behalf of individual employer groups. Consequently, if an employer group has a year in which several policy holders have high medical expenses, the premium for the group usually climbs the following year to reflect the group's experience.

The advantage of this process for determining health insurance premiums is that people who may be perceived to be low risk in a particular year are not subsidizing people who are viewed as being high risk in that particular year. However, this practice of determining health insurance premiums has costs, some of which are not obvious.

In particular, the assessment of risk and the resulting structure of premiums play an increasing role in our country's firms' decisions about whom to hire and whether to expand production at all. I do not think that health insurance should have such a major role in our discussions or decisions about production.

Beyond the 35 million people who lack health insurance at a given time, there is a growing number of people who are at risk of losing their health insurance altogether, or for losing coverage for medical conditions they currently have. During the last 5 years there has been a rapidly increasing number of Americans who work for employers that self-insure, rather than purchasing commercial health insurance for their workers.

Employers that self-insure are exempt under the Federal Employee Retirement Income Security Act, ERISA, from State mandates about the types of benefits that must be included under health insurance policies sold within the State. Thus, employers have discovered that they save considerable amounts of money on health insurance benefits for their employees if they self-insure and do not provide all the benefits required under the State laws for health insurance.

But the Supreme Court decision last fall to affirm a 1991 U.S. Court of Appeals decision in the case of *H & H Music Company v. McGann* should serve as a warning to all of us. That decision permitted the music company, which had decided to become a self-insured firm, to retroactively impose a limit on how much the music company would pay for medical care related to AIDS.

There have been numerous other employer court decisions that similarly have found that self-insured firms are permitted under

ERISA to retroactively alter what they are paying for in terms of medical care expenses of employees and their dependents. The increasing number of American workers who have employers that self-insure places a majority of Americans at risk for discovering that their health insurance coverage is nonexistent for care they may need.

The second point is that people without health insurance are not a homogeneous group of people. Nancy Gordon and CBO have already detailed these differences so I will not repeat them here. They are in some of my written tables.

However, I do want to comment that requiring employers to provide health insurance to employees will not provide the quick fix to the problem of uninsured people that it appears at first glance. Recent research that I and my colleagues have done indicates that almost half of all uninsured spells end within 6 months, and only about 15 percent of all uninsured spells last more than 2 years. We have found that people with jobs are highly likely to have the short spells and people with long spells are those with lower educational attainment and lower incomes, people who are most likely to need subsidies if they are to cover their dependent family members.

But, we have not been able to use the observable characteristics of people to identify a priori, who, among a group of people, are likely to have long uninsured spells and who are going to have short spells. I conclude from this that only a national plan with health insurance for all Americans makes sense.

The increasingly sophisticated efforts by insurance companies and employers to avoid risky insurance prospects makes the problem of providing insurance to the uninsured increasingly urgent. The 35 million number of uninsured does not capture either the number of people who experience a spell without health insurance during a year, or the number of people who are very afraid of not having health insurance for a medical condition in the future.

I do not believe that insuring financial access to health care to all Americans is something that must wait until we have control over health care costs. On the contrary, I believe that when all Americans are guaranteed health insurance, cost control will be easier. I applaud your efforts to make headway on these problems.

Thank you.

[The prepared statement and attachments follow:]

Testimony before the Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

by Katherine Swartz, Ph.D.
Associate Professor
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January 26, 1993

Thank you very much for inviting me to testify on what I believe is one of the most pressing issues in health care reform: the 35.2 million nonelderly Americans who, as of last March, do not have health insurance. This estimate of 35.2 million reflects an increase of almost 4 million people since 1988.¹

I want to make three points this morning: (1) the increase in the number of Americans without health insurance is partially due to the economic recession but it is also due to current industry trends that are taking the insurance out of health insurance, (2) the people without health insurance are not all alike in terms of their incomes and other characteristics, and (3) the lengths of time that people spend without health insurance are also quite varied.

Our current system of health insurance is moving toward a world in which only the young and healthy will have insurance, and that insurance will not really bear the risk of large, unanticipated medical expenditures. As you know, most health insurance companies set premiums using experience rating, rather than community rating. Experience rating encourages insurance companies to do as much as possible to separate low-risk individuals from high-risk individuals and to set premiums accordingly. If a person is a member of an employer-group and the group purchases health insurance, the group's premium is based on a composite profile of the health risks of the group's members and these risks are not always avoidable. Thus, if the employer-group is young it will be in a lower-risk, lower rate category than an older employer-group.

The increasing sophistication of computerized insurance records now permits insurance companies to examine the flows of expenditures made on behalf of individual employer-groups. Consequently, if an employer-group has a year in which several policy holders had high medical expenses, the premium for the group usually climbs the following year to reflect the group's experience. This is not insurance in the sense we have come to understand the word.

The primary advantage of this process for determining health insurance premiums is that low-risk people are not subsidizing high-risk people. However, this process of determining health insurance premiums has costs, some of which are not obvious. In particular, the assessment of risk and the resulting structure of premiums plays an increasing role in firms' decisions about whom to hire and whether to hire more employees at all. If an employer believes that hiring another worker would increase profits, the employer must now think twice about the relative costs and benefits of a young, inexperienced worker versus an older but experienced worker. A major cost in such calculations is what effect the two choices will have on the firm's relative risk assessment by an insurance company. Do we as a society want health insurance to have such a major role in firms' decisions about expanding production? Why is it better for inexperienced but younger workers to be preferred to experienced but older workers?

Weighing the benefits and costs of expanding production is far more serious for a small than a large employer because small firms' risk assessments depend critically on who works for the firm. Should decisions regarding the optimal size of operations be so strongly affected by health insurance? Big may be better for health insurance purposes but perhaps

¹ Estimates of the number of Americans without health insurance are sensitive to the exact wording of survey questions, but the wording of the Census' Current Population Survey health insurance questions did not change between 1988 and 1992.

not for managing the development of some products, such as computer software.

As you know, and despite experience rating, health insurance premiums have increased rapidly in recent years. The expense, *per se*, has also contributed to reduced coverage. One trend in this area involves employers (including local governments) who lay off workers to avoid paying benefits -- and then rehire the same workers (or others) on a temporary basis or as if the workers were self-employed contractors or consultants. This is a very attractive method of dealing with ebbs and flows of production needs, particularly in white-collar and service industries: it permits the employers to free themselves of paying fringe benefits.

Beyond the 35.2 million people who lack health insurance at a given time, there is a rapidly growing number of people who are at risk of losing their health insurance altogether or for losing coverage for medical conditions they currently have. During the last five years there has been a rapidly increasing number of Americans who work for employers that self-insure rather than purchase health insurance for their workers. Employers that self-insure are exempt under the federal Employee Retirement Income Security Act (ERISA) from state mandates about the types of benefits that must be included under health insurance policies sold within that state. Thus, employers have discovered that they save money on health insurance benefits for employees if they self-insure and do not provide all of the benefits required under the state laws for health insurance.

But the Supreme Court decision last fall to affirm a 1991 U.S. Court of Appeals decision in the case of *H and H Music Company vs. McGinn* should serve as a warning. That decision permitted the Music Company, which had self-insured, to impose a limit of \$5,000 on how much the Music Company would pay for medical care related to AIDS. There have been numerous other court decisions that similarly have found that self-insured firms are permitted, under ERISA, to retroactively alter what they are paying for in terms of medical care expenses of employees and their dependents. These court cases have by and large involved chronic medical conditions.

The ultimate outcome of these court decisions and the increasing use of experience rating by insurers is that the insurance aspect of health insurance is disappearing. Only expected medical costs for basically healthy individuals are likely to be reimbursed. (One can only wonder why sports injuries will be covered but care for multiple sclerosis or muscular dystrophy will be limited.) The increase in the number of American workers who have employers that self-insure employees places a majority of Americans at risk for discovering that their health insurance coverage is non-existent for care they may need.

The second point I want to make today is that people without health insurance are not a homogeneous group of people. The data I am going to use come from surveys conducted by the Bureau of the Census. The descriptions of the characteristics of the uninsured have not changed very much over the past ten years, which indicates that the increases in the number of uninsured Americans have come from all sectors of our society.

The top graph in Figure 1 shows how different the uninsured are in terms of family income relative to the poverty level. (In 1991, a family of four with an income below \$14,000 was categorized as being in poverty.)

- o Not quite 30 percent of the uninsured were in families with incomes below the poverty level -- contrary to what the media often says, Medicaid does not cover all of the poor.

- o Almost a third of the uninsured are in families with incomes that might be described as near-poor -- between one and two times the poverty level.

- o The remaining almost 40 percent of the uninsured live in families with incomes above two times the poverty level - that is, incomes above about \$20,000.

A point of clarification here: while 40 percent of the uninsured live in families with incomes above two times the poverty level (roughly \$23,000 for all sizes of families), the proportion of people in families with incomes above two times the poverty level without health insurance is quite low - about 8 percent. Conversely, the proportion of all people in poverty without health insurance is about 30% (see the lower half of Figure 1). In thinking through policy proposals to eliminate the number of people without health insurance, it is useful to keep in mind that the people with the highest risk of being uninsured are those with the lowest incomes.

Figure 2 shows how different the uninsured are by age.

- o A quarter of the uninsured in this country are children under the age of 18 -- children without insurance usually because their parents lack insurance.

- o Another fifth are young adults between the ages of 18 and 24 years of age, many of whom work on jobs that do not provide health insurance. Thus, almost half of the uninsured are people below the age of 25.

- o Another 25 percent are adults between the ages of 25 and 34 years of age.

The lower graph of Figure 2 indicates the proportions of each age cohort that are not insured. Clearly, the age cohorts most at risk of being uninsured are children and adults younger than age 35.

Figure 3 is a map of the United States indicating where the uninsured live and the proportions of the population in each region who are without health insurance. The point I want to make here is that people living in the south and southwest of the country have higher probabilities of being without health insurance. This pattern seems highly linked to the fact that states in those regions have relatively low income eligibility ceilings for Medicaid.

Figure 4 indicates why proposals to require employers to provide health insurance are so popular. Almost 60 percent of the adults without health insurance at any given time are employed. I will not dwell on these numbers because Mr. Salisbury will be focusing on them.

However, requiring employers to provide health insurance to employees will not provide the quick fix to the problem of uninsured people that it appears at first glance. Recent research that I and my colleagues have done indicates that almost half of all uninsured spells end within six months and only about 15 percent of all uninsured spells last more than two years. The Bureau of the Census has estimated that 62 million people experience at least a month without health insurance over a 28 month period. We have found that people with jobs are highly likely to have short spells. People with long spells are those with lower educational attainment and lower incomes -- people most likely to need subsidies if they are to cover their dependent family members. Thus, the figure that 80 percent of the uninsured are in families with at least one employed adult does not reflect how an employer mandate would work. Many of the employed uninsured will find jobs with health insurance anyway within six months, and the remaining uninsured will not be able to afford to cover their dependents if an employer pay or play plan is enacted.

In the past, policy analysts and policy makers believed that if we could identify characteristics that are amenable to government assistance, we could provide health insurance coverage for the uninsured. However, the increasingly sophisticated efforts by insurance companies and employers to avoid risky insurance prospects makes the problem of providing insurance to the uninsured increasingly urgent. The 35.2 million number of non-elderly people without health insurance last March does not capture either the number of people who experience a spell without health insurance during a year or the number of people who are afraid of not having health insurance for a medical condition in the future.

Thus, the number of people without health insurance is not just an unfortunate problem -- it symbolizes a problem that most Americans worry about. I do not believe that ensuring financial access to health care to all Americans is something that cannot be accomplished until we have control over health care costs. On the contrary, I believe that when all Americans are guaranteed health insurance, cost control will be easier. I applaud this committee's efforts to make headway on these problems. Thank you.

Figure 1: Nonelderly Uninsured by Family Income Relative to Poverty, 1989 Incomes

A. As Percentage of Total Nonelderly Uninsured B. As Percentage of Family Income Group

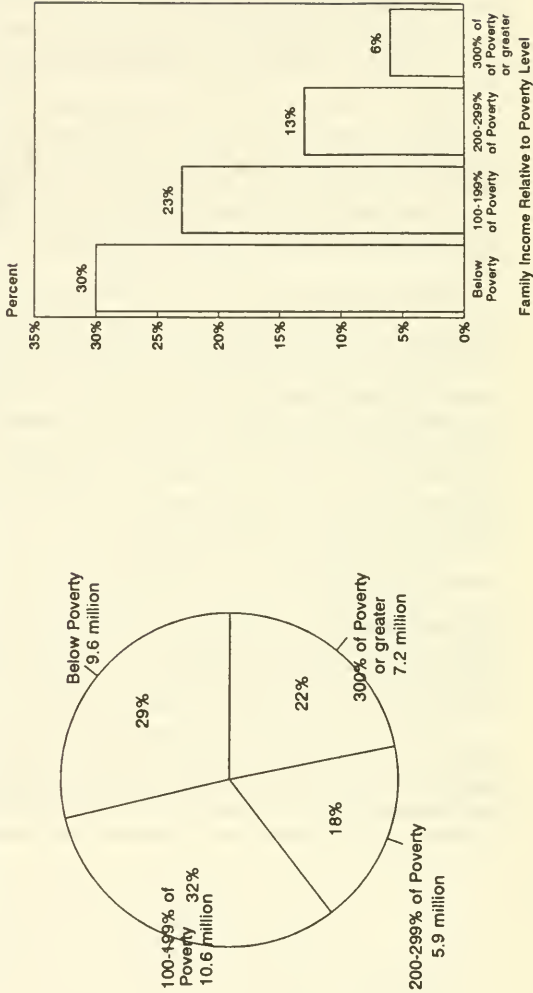
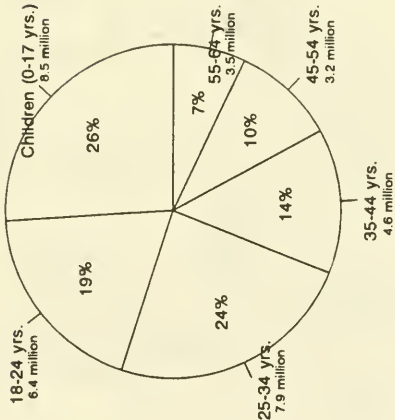
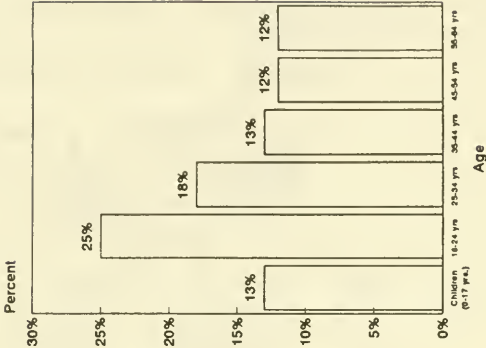


Figure 2: Nonelderly Uninsured by Age, 1990

A. As Percentage of Total Nonelderly Uninsured

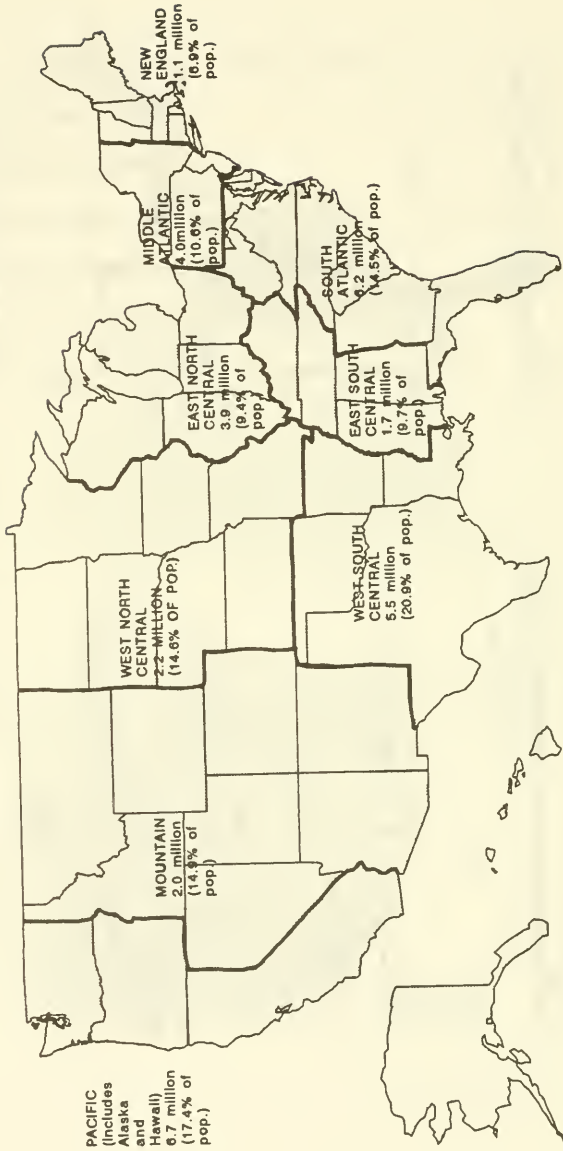


B. As Percentage of Age Group



Source: 1990 Current Population Survey, Courtesy of Congressional Budget Office

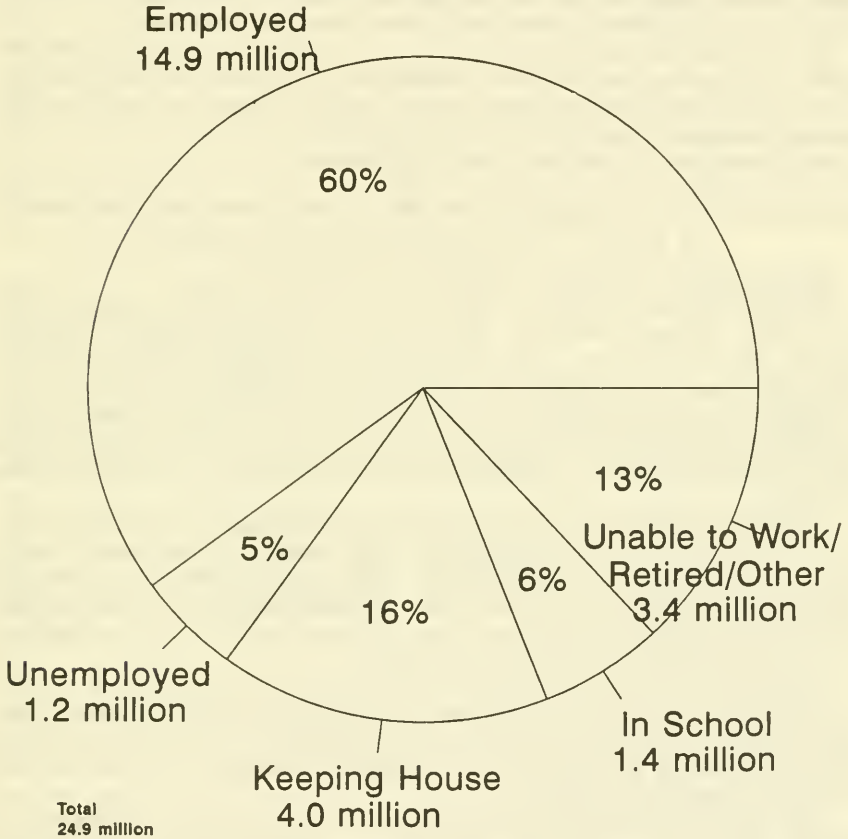
Figure 3: Regions



Source: 1990 Current Population Survey, Courtesy of Congressional Budget Office

Figure 4: Adults Ages 18-64 Without Health Insurance by Labor Force Status, 1990

As Percentage of Total Prime Age Uninsured



Source: 1990 Current Population Survey, Courtesy of Congressional Budget Office

Mr. ANDREWS [presiding]. Dr. Swartz, is it true that most of the uninsured are working Americans right now, and is it also true that most of them tend to work for small, not large employers; is that right?

Ms. SWARTZ. Well, most of the uninsured are not workers, since roughly a quarter of them are children, but if you take out the children and you look at the adults, at a point in time roughly 60 percent of them are employed. But many of them work part time and are not eligible for health insurance as a consequence of that, and I think that Rick Brown will talk about part of this.

But as well, it is not at all clear to me that this figure of 80 percent of all uninsured people are attached to somebody who works is correct. So I will leave some of this to Rick Brown, as well, to address, because I think part of his testimony covers it.

Mr. ANDREWS. Let's hear from Dr. Brown.

STATEMENT OF E. RICHARD BROWN, PROFESSOR, UCLA SCHOOL OF PUBLIC HEALTH, LOS ANGELES, CALIF.

Mr. BROWN. Thank you. Thank you, Mr. Chairman.

Good afternoon and thank you for inviting me to present testimony on current trends in insurance coverage and cost. What I would like to do today is to summarize very briefly the conditions that we face in California, which is significant, I think, on a number of counts because of the severity of the health care financing problems in the largest State in the union, and the State from which both the Chair and the ranking member of the committee come.

California faces a double whammy in health care financing problems. We have an extraordinarily large number of people, a very high proportion of our population, who are completely uninsured for health expenses, and we have exceptionally high health care costs in California. Health care costs are out of control in California as they are throughout the country.

California's problem, however, is worse. It ranks second among the States in total per capita health spending, one-fifth higher than the national average. This is true despite efforts by employers and by Government to individually attempt to control the rate of increase in health care costs.

We have the highest proportion of our population enrolled in HMOs of any State in the country, some 34.5 percent of the entire State, which represents actually one out of every four persons nationally who are enrolled in HMOs. We also have a very high proportion of our State's population enrolled in PPOs, preferred provider organizations.

Employers use these and other methods of controlling utilization, restricting choice of provider, and contracting with doctors and hospitals for discount rates, frankly, to little avail in being able to control the rate of growth in health spending. What has not been tried, however, is collective action among all payers acting jointly on behalf of their common interests in controlling costs.

Turning to the insurance coverage side of the problem, 6 million Californians are without any coverage; 22.5 percent of the nonelderly population. The uninsured rate in California is more than a

third higher than the national average, and Los Angeles itself has the highest uninsured rate among the 30 largest metropolitan areas in the country, with one out of every three of its nonelderly population completely uninsured.

In California nearly 2 million of the uninsured are children who represent about one-third of all of the uninsured in the State. Young adults, 18 to 29 years of age, are themselves—in that short age span—roughly another third of the uninsured. They have the highest uninsured rate. And in California, one out of every three of these young adults are completely uninsured compared to 1 in 4 nationally.

More than 40 percent of uninsured Californians are in families with very low incomes. This is very important in developing and considering public policy solutions to the problem, because this low income population cannot be expected to contribute really anything for the costs of their own coverage or medical care. Nearly a third of the uninsured have low or moderate incomes, limiting their ability to contribute to their own coverage.

A shocking 42 percent of all nonelderly Latinos in California are without any health insurance coverage, public or private, nearly three times the rate for non-Latino whites and more than twice the rate for African-Americans and Asians.

The uninsured rates for both Latinos and non-Latino whites are higher in California than they are nationally. This is a problem that cuts across ethnic group lines and is related to the fact that we maintain our health insurance coverage through employment, and basically below that level is the problem of the structure of the labor market and the economy, both in California and nationally.

Nearly 9 out of every 10 uninsured persons in California, 87 percent of all of the uninsured, are workers and their families. Two-thirds are full time employees, and their immediate dependents. California's economy, compared to the United States as a whole, channels more workers into part-year employment and into small firms and industries that are less likely to provide health benefits.

For example, in California 32 percent of full time full year employees work in low coverage industries compared to 28 percent nationally. The growth of jobs over the past decade has been much greater in these low coverage industries than in other sectors of the economy. The number of employees in California, for example, increased 27 percent in the 10 year period between 1979 and 1989, but employment in these low coverage industries increased 40 percent during that period.

Small firms are more predominant in both low and high coverage industries in California, compared to the United States as a whole. Latinos' higher uninsured rates are fundamentally due to their disadvantaged position in the labor market. They are more likely to work in low coverage industries and in small firms, and they are less likely to get health benefits regardless of the type of firm in which they work, compared to non-Latino whites.

Health insurance coverage is important because it provides essential access to necessary medical care, both care for acute conditions and chronic conditions, as well as access to preventive health services. Furthermore, the lack of insurance puts both patients and other payers at financial risk.

Among those who pay for health insurance coverage of the employed population, they have, of course, been the subject of a considerable amount of cost shifting in recent years by private hospitals. However, in California with the very high proportion of our population enrolled in HMOs and PPOs, we find that the margin that hospitals have to shift those costs for uninsured patients to privately insured patients has been dramatically reduced.

The effect of that reduction has been that there is no more margin really for cost shifting in many private hospitals. They have taken steps, therefore, to keep out uninsured patients by closing down or reducing their emergency services, keeping out 911 rescue ambulances. In Los Angeles, private hospital emergency rooms have declined since 1980 from 103 to 85, and private hospital trauma centers have been cut in half from 20 to only 10, plus three county trauma centers for a population of 9 million people in some 4,000 square miles. This reduces access to essential medical services for the entire community.

What are the implications of the California situation for public policy?

I believe that, first of all, at least in California, conditions will get even worse before they get better. The State has a very high unemployment rate; one out of every 10 California workers is without a job. That means that even more workers and their families are losing health benefits every month. The continuing budget shortfall in the State, an additional \$9 billion this year, means that there will be more cutbacks in public health, social and education programs at all levels, eliminating the slack that many people have tended to rely on when left uninsured.

Below-average wages of uninsured workers and their concentration in small firms makes the situation even more intractable. It is hard to expand coverage through employment-based health insurance because of the severe adverse impact that it may have on the employment of people in lower wage occupations and small firms.

Both employee contributions and employer contributions, therefore, must be based on ability to pay, so that lower income workers' share of cost does not deprive them of funds needed for other essentials, and so that the increased labor costs that would accrue to small firms would not deprive those firms of their existence and their employees of their own earnings.

Given the current system of paying for health care services, of course, expanded coverage would fuel the flames of medical costs, and therefore, California's situation requires both a national solution and within that solution, a clear attention, both to universal insurance coverage and controlling, effectively controlling the increase in costs.

And I thank you very much for inviting me to present testimony on California.

[The prepared statement follows:]

**STATEMENT OF E. RICHARD BROWN, PH.D., PROFESSOR,
UCLA SCHOOL OF PUBLIC HEALTH, LOS ANGELES, CALIF.**

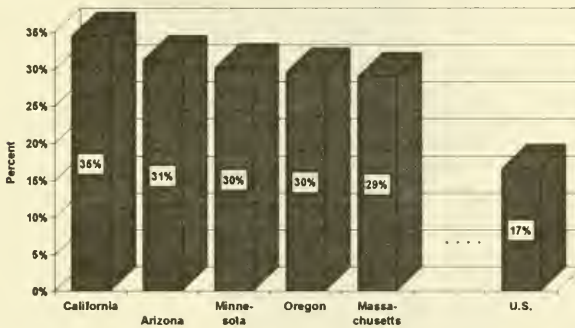
Good morning, Mr. Chairman and members of the Committee. My name is Richard Brown, and I am professor of public health at UCLA. I am pleased to be invited to provide testimony about the problems of insurance coverage and health care financing in California, a subject that I have studied extensively.

California faces a double whammy of health care financing problems. The state has an extraordinarily large number of residents who are completely uninsured for medical expenses. At the same time, California has been no more successful than other states in controlling its exceptionally high health care costs. The combination of these two forces -- runaway costs and a large and growing uninsured population -- has fueled political support to reform the way we finance health care.

Health Care Costs Are Out of Control

California, like other states, is burdened by unrestrained increases in health care costs and spending. But California's problem is worse than most states; it ranks second among the states in total per capita health spending, one-fifth higher than the national average.¹

Figure 1. Percent of Population Enrolled in HMOs, 1992



Source: *Marion Merrell Dow Managed Care Digest*, 1992

California's costs have continued to rise uncontrollably despite efforts taken individually by employers and the state to bring costs under control. More than one-third (34.5 percent) of the state's entire population is enrolled in health maintenance organizations (HMOs), the nation's highest rate (see Figure 1). California accounts for one-fourth of the nation's entire HMO enrollment.² In addition, an increasing proportion of the population is enrolled in the state's 104 preferred provider organizations (PPOs).³ Employers have tried to control their costs by encouraging or pushing their employees into HMOs, PPOs and other arrangements that control utilization, restrict choice of provider, and/or contract with doctors and hospitals for discount payment rates.

These efforts obviously have not succeeded. As the president of the California Council of Employer Health Care Coalitions has said, "We have tried a lot of things -- utilization review, case management, cost sharing with employees, health maintenance organizations, preferred

¹ National Governors' Association, *A Healthy America: The Challenge for States*. Washington, DC: NGA, 1991.

² *Marion Merrell Dow Managed Care Digest*, Update Edition, 1992. Kansas City, MO: Marion Merrell Dow Inc., 1992.

³ *Marion Merrell Dow Managed Care Digest*, PPO Edition, 1992. Kansas City, MO: Marion Merrell Dow Inc., 1992.

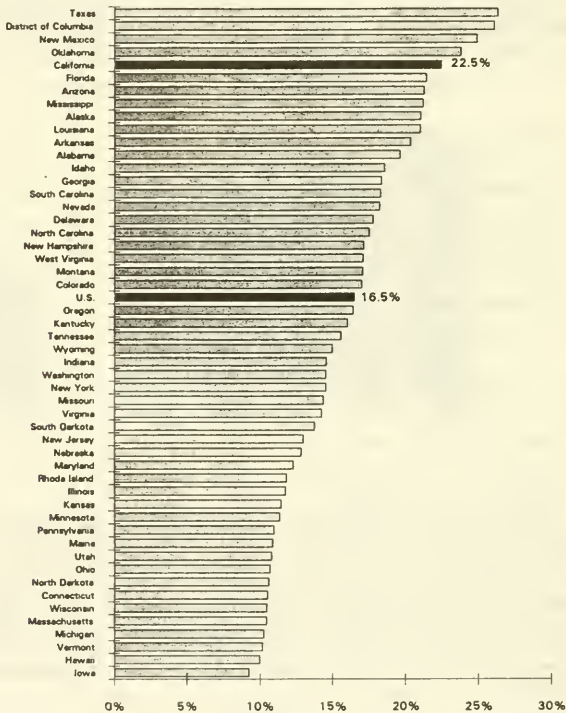
providor organizations, hospices -- and costs are still going up 20 to 30 to 40 percent."⁴ What has not been tried, however, is collective action, in which all payers join together on behalf of their common interests in controlling costs.

Employers and employees continue to struggle under the burden of cost increases that compete with desires to raise wages, invest more capital in business, and reduce prices to make firms more competitive. Rising health care costs also drain individual, family and public resources from other types of spending -- for education, housing, nutrition, and leisure time, thereby reducing our standard of living. Rising costs also have made it difficult for many firms, but especially small businesses, to provide health benefits to their employees.

6 Million Californians Are Uninsured

Six million Californians -- 22.5 percent of the population under 65 years of age -- are uninsured.⁵ These Californians have no private health insurance, Medicare, Medicaid, or any other coverage.

Figure 2. Percent Uninsured Nonelderly Persons by State, U.S.



Source: Brown ER et al., *Health Insurance Coverage of Californians in 1989*, Berkeley: California Policy Seminar, University of California, 1991, based on authors' analyses of March 1990 Current Population Survey.

⁴ Holzman D, "Rising Cost of Insuring Workers," *Insight*, 5(3), Jan. 16, 1989, pp. 54-55.

⁵ Brown ER, Valdez RB, Morgenstern H, et al. *Health Insurance Coverage of Californians in 1989*, Berkeley: California Policy Seminar, University of California, 1991. The estimates of health insurance coverage are based on the authors' analyses of the March 1990 Current Population Survey.

Californians are more likely than most other Americans to be uninsured{tc "Californians are more likely than most other Americans to be uninsured"}{

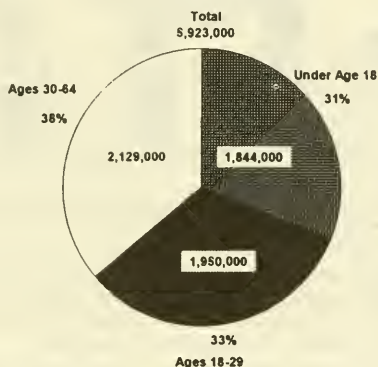
This uninsured rate in California is more than one-third higher than the national average of 16.5 percent (see Figure 2), and it is higher than all but three other states -- Texas, New Mexico, and Oklahoma -- and the District of Columbia.

Los Angeles County leads the nation with the highest uninsured rate among the 30 largest metropolitan statistical areas in the country. Nearly one in every three nonelderly persons in Los Angeles -- 2.7 million people -- is uninsured. Orange and San Diego counties rank fifth and seventh with uninsured rates of 22 percent and 20 percent, respectively.

The young are most likely to be uninsured{tc "The young are most likely to be uninsured"}{

More than 1.8 million children under age 18 in California -- nearly one in four of the state's children -- are uninsured. Children represent nearly one-third of all uninsured Californians (see Figure 3).

Figure 3. Distribution of Uninsured Nonelderly Persons by Age Group, California



Source: Brown ER et al., *Health Insurance Coverage of Californians in 1989*, Berkeley: California Policy Seminar, University of California, 1991, based on authors' analyses of March 1990 Current Population Survey.

California's children are more likely to be uninsured than children in the United States as a whole (23 percent in California compared with 17 percent nationally).

Young adults, 18 to 29 years of age, however, are the most likely to be uninsured among all age groups. Nearly 2 million young adults are without any coverage -- one in every three in California, compared to less than one in four for the U.S. as a whole. This one narrow age span accounts for more than one-third of all uninsured people in California (see Figure 3).

Adults 30 to 64 years of age are least likely to be uninsured. These 2.1 million adults represent a little more than one-third of all the uninsured in the state.

Lower-income children and adults are more likely to be uninsured{tc "Lower income persons are more likely to be uninsured"}{

More than 40 percent of uninsured Californians are in families with very low incomes -- 24 percent with family incomes below the federal poverty level (in 1989, \$12,675 or less for a family of four) and another 19 percent who are "near-poor" (family income of \$19,000 or less).

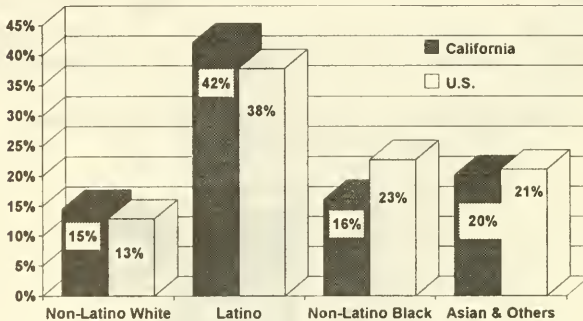
Nearly a third of the uninsured have lower-moderate incomes (with family incomes

between 150 and 299 percent of the poverty level). One-fourth, however, have family incomes of 300 percent of the poverty level or more (at least \$38,000 for a family of four), placing them in the upper half of the income distribution in the state.

Latinos are the ethnic group most likely to be uninsured{tc "Latinos are the most likely to be uninsured"}

A shocking 42 percent of all nonelderly Latinos in California are without any private or public coverage, nearly three times the rate for non-Latino whites and more than twice the rates for African Americans and Asians and others (Figure 4).

Figure 4. Percent Uninsured Nonelderly Persons by Ethnic Group, California and U.S.



Source: Brown ER et al., *Health Insurance Coverage of Californians in 1989*, Berkeley: California Policy Seminar, University of California, 1991, based on authors' analyses of March 1990 Current Population Survey.

The uninsured rates for Latinos and non-Latino whites are higher in California than for these groups in the United States as a whole. Lack of health insurance is a problem that cuts across ethnic group lines. It is rooted in the provision of health insurance through employment and, as we will see, in the structure of the economy and the labor market.

Nearly nine out of ten uninsured Californians are workers or in families headed by a worker{tc "Nearly nine out of ten uninsured Californians are workers or in families headed by a worker"}

California's uninsured are overwhelmingly working people and their families. More than half of all uninsured Californians are themselves working adults.

Nearly 9 out of every 10 uninsured people in California -- 87 percent of all the uninsured -- are workers or in a family headed by at least one worker (Figure 5). Two-thirds of the uninsured -- 3.8 million Californians -- are full-time employees and their dependent spouses and children. Another 22 percent, 1.3 million uninsured persons, are part-time employees and the self-employed and their dependents.

California's economy makes job-based health benefits less likely for its workers

California's economy, compared to the U.S. as a whole, channels more workers into part-year employment and into small firms and industries that are much less likely to provide health benefits. A larger share of California's employment is in industries that are less likely to provide coverage to their employees. In California, 32 percent of full-time full-year employees work in low-coverage industries (that is, agriculture, forestry, fisheries; mining; construction; retail sales; business and repair services; and personal and entertainment services), compared to 28 percent nationally. In these low-coverage industries in California, 55 percent of full-time full-year

employees get their own health benefits, compared to 78 percent of those who work in high-coverage industries (that is, manufacturing; transportation, communication, and utilities; wholesale trade; finance, insurance, and real estate; professional services, and public administration).

Figure 5. Uninsured Nonelderly Persons by Work Status of Adults in Living Unit, California

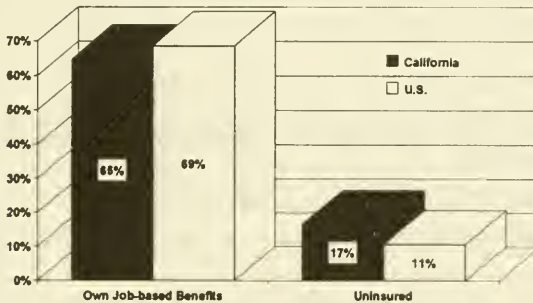


Source: Brown ER et al., *Health Insurance Coverage of Californians in 1989*, Berkeley: California Policy Seminar, University of California, 1991, based on authors' analyses of March 1990 Current Population Survey.

Furthermore, the growth of jobs over the past decade has been greater in these low-coverage industries than in other sectors of the economy. The number of employees in California increased 27 percent between 1979 and 1989, but the number employed in these low-coverage industries increased 40 percent during this period.

California workers are less likely than other U.S. workers to receive health benefits through their own jobs, reflected in lower employment-based coverage rates for all age groups, income levels, and most ethnic groups. Full-time full-year employees in California are less likely to receive these benefits, and more likely to be uninsured, than their counterparts nationally (see Figure 6).

Figure 6. Percent of Full-time Full-year Employees Who Have Own Employment-based Health Benefits and Who Are Uninsured, California and U.S.



Source: Brown ER et al., *Health Insurance Coverage of Californians in 1989*, Berkeley: California Policy Seminar, University of California, 1991, based on authors' analyses of March 1990 Current Population Survey.

Low-coverage industries include a much higher percentage of small firms which, in all types of industry, are far less likely to provide their employees with health benefits. Small firms are more predominant in both low- and high-coverage industries in California than in the U.S. as a whole.⁶ Among full-time full-year employees in California, for example, 55 percent of workers in low-coverage industries and 29 percent of those working in high-coverage industries are employed in firms with fewer than 100 employees. Nationally, 50 percent of those in low-coverage industries and 24 percent of those in high-coverage industries work in such small firms.

This higher proportion of employment in small firms contributes to the higher uninsured rates in California. Almost half of all uninsured employees (47 percent) work in firms with fewer than 25 workers. Small firms argue that they cannot provide these benefits because their profits are too low and the cost of insurance is too high. Furthermore, the health insurance market for small groups is drying up.⁷

Latinos have higher uninsured rates because they are more disadvantaged in the labor market

Latinos are more likely to work in low-coverage industries and in small firms and, regardless of their type of employer, are less likely to get health benefits. One in every 10 Latino workers, for example, is employed in agriculture, compared to less than 2 percent of all other ethnic groups. Among full-time full-year employees, 42 percent of Latinos work in low-coverage industries, compared to 30 percent or less of non-Latino ethnic groups. And among these employees in low-coverage industries, Latinos are only about half as likely as members of other ethnic groups to have their own job-based health benefits; only 34 percent of Latinos get these benefits compared to more than 60 percent of other ethnic groups.

In addition, Latinos are much more likely than any other group to work in small firms. For example, 30 percent of full-time full-year Latino employees work in firms with fewer than 25 workers, compared to only 18 percent of non-Latino whites. And 19 percent of these Latino full-time full-year employees work in small firms in low-coverage industries, twice the proportion for non-Latino whites (9 percent). Only 34 percent of Latinos work in large firms (100 or more employees) in high-coverage industries, compared to 52 percent of non-Latino white employees.

Moreover, Latinos in each group are far less likely than non-Latino whites to have their own job-based health benefits. Just 15 percent of full-time full-year Latino employees working in small firms in low-coverage industries have their own work-based health insurance, compared to 39 percent of non-Latino whites. Although 78 percent of Latinos in large firms in high-coverage industries have these benefits, 87 percent of non-Latino whites have them.

These labor-force and other economic factors have given Latinos the highest uninsured rate among all ethnic groups. Among working adults, 43 percent of Latinos are completely uninsured, almost twice the rate for any other ethnic group. Thus, the lack of health insurance among Latinos reflects problems in the structure of the economy and the labor market and in employment opportunities available to Latinos. And it provides a poignant example of the inadequacies of the current private employment-based health insurance system.

Why is health insurance important? {c "Why is health insurance important?"}

Health insurance is important because it provides access to necessary health care, and because it protects patients against the high costs of medical care and distributes fairly the burden of paying for health care.

The uninsured have less access to necessary health care

First, the uninsured receive less physician and hospital care than the insured with

⁶ Small Business Administration, *The State of Small Business: A Report of the President*. Washington, DC: U.S. Government Printing Office, 1987.

⁷ Ibid.; Reich K, "Allstate's Dropping of Small Group Health Coverage Stings Many," *Los Angeles Times*, July 15, 1989, Part II, pp. 1, 4; White G, "The Uninsured. Health Gamble Affects 1 in 5," *Los Angeles Times*, January 29, 1990, pp. A1, A16.

equivalent health status. Compared to people with insurance, the uninsured are less likely to see a physician in a 12-month period, and they are only half as likely to see a physician within 30 days if they have serious symptoms, such as persistent high fever, nausea, or bleeding.⁸

The lack of adequate access to health care has a direct impact on health status. Uninsured women are more likely to have adverse birth outcomes. Lack of medical care among people with chronic illnesses may lead to otherwise avoidable suffering, disability, loss of income, and added medical expense, such as hospitalization. Loss of coverage among patients with chronic illnesses, such as diabetes or high blood pressure, has been found to have a serious adverse impact on health status. And among people admitted to a hospital, the average uninsured patient is sicker than those with private coverage, and appears in more urgent need of care.⁹

The uninsured also are less likely to get important preventive health care, such as getting their young children adequately immunized, starting prenatal care in the important first trimester of pregnancy, and having their blood pressure checked. Uninsured women are less likely to have blood pressure screening, glaucoma testing, clinical breast examination, and Papanicolaou smear.¹⁰

Lack of insurance puts patients and other payers at financial risk

The lack of adequate health insurance coverage puts individuals and families at risk for significant economic losses due to medical expenses. The uninsured spend more out-of-pocket for medical care than do insured individuals and families.¹¹

In addition, providers, government, employers, and families and individuals end up paying for "uncompensated" care provided to uninsured persons. When the uninsured need urgent care, they usually go to hospital emergency rooms and clinics. Care to uninsured patients cost hospitals in California \$975 million in fiscal year 1985-86 -- 84 percent more than in 1981-82, 49 percent more after adjusting for inflation. Taxpayers shoulder the financial burden of uncompensated care provided by public hospitals -- \$468 million in 1985-86. Employers and employees pay for the uncompensated care provided by private hospitals.¹² But as such "cost shifting" has become more difficult over the last few years, more and more private hospitals have closed their trauma centers or downgraded their emergency services, shutting their emergency room doors to "911" rescue ambulances. In Los Angeles, private hospital emergency rooms have declined since 1980 from

⁸ Brown ER, Valdez RB, Cumberland W, et al. "The Medically Indigent in California," *Journal of American Medical Association* (submitted for review); Wilensky GR, Berk ML. "Poor, sick, and uninsured." *Health Affairs* 1983; 2(2): 91-95; Andersen R, Aday LU, Lyttle CS, Cornelius LJ, Chen MS. *Ambulatory Care and Insurance Coverage in an Era of Constraint*. University of Chicago, Center for Health Administration Studies, Research Series No. 35. Chicago: Pluribus Press, 1987; Davis K, Rowland D. "Uninsured and underserved. Inequities in health care in the United States." *Milbank Memorial Fund Quarterly* 1983; 61: 149-176; Freeman HE, Blendon RJ, Aiken LH, et al., "Americans Report on Their Access to Health Care," *Health Affairs*, 6 (1987): 6-18.

⁹ Braveman P, et al. "Adverse outcomes and lack of health insurance among newborns in an eight-county area of California, 1982 to 1986." *New England Journal of Medicine*, 1989; 321: 508-513; Valdez RB, Dallek G. *Does the Health Care System Serve Black and Latina Communities in Los Angeles County? An Analysis of Hospital Use in 1987*. Claremont, CA: Tomas Rivera Center, 1991; Lurie N, Ward NB, Shapiro MF, et al. "Termination of Medi-Cal benefits: A follow-up study one year later." *New England Journal of Medicine* 1986; 314:1266-1268; Weissman JS, Stern R, Fielding SL, Epstein AM. "Delayed access to health care: Risk factors, reasons, and consequences." *Annals of Internal Medicine* 1991; 114: 325-331.

¹⁰ Freeman HE, et al., "Americans Report on Their Access to Health Care"; Woolhandler S, Himmelstein DU. "Reverse targeting of preventive care due to lack of health insurance." *Journal of the American Medical Association* 1988; 259: 2872-2874.

¹¹ Monheit AC, Hagan MM, Berk ML, Farley PJ, "The Employed Uninsured and the Role of Public Policy," *Inquiry*, 1985, 22: 348-364.

¹² Sofaer S, Rundall TG, Zellers WL, "Restrictive Reimbursement Policies and Uncompensated Care in California Hospitals, 1981-1986," *Hospital and Health Services Administration*, 1990, 35: 189-206.

103 to 85, and private hospital trauma centers, from 20 to only 10.¹³ These actions reduce access to essential medical services for the entire community -- people with insurance as well as the uninsured.

Implications for Policy Makers

Uncontrolled increases in health care costs and continuing growth in the uninsured population add urgency to the need for reform. The continuing deterioration in California's economy suggests that conditions will get even worse before they get better. The state's high unemployment rate -- one in every ten California workers is unemployed, one of the highest rates in the nation -- means that even more workers and their families are losing health benefits. The continuing budget shortfall means that, rather than ameliorating these problems by expanding public programs, the state is bracing for more cutbacks in health, social and education programs at all levels.

The low average wages of uninsured workers and their concentration in small firms make the situation even more intractable because it will be hard to expand coverage through employment-based health insurance. More than one-third of uninsured employees in California have family incomes below 150 percent of the poverty level; these very-low-income workers and their families cannot be expected to contribute any of their limited resources to pay for the costs of expanded coverage. Another third earn modest incomes, between 150 and 299 percent of the poverty level; they can be expected to contribute only partially to the costs of their coverage. Employee contributions, therefore, must be based on ability-to-pay so that lower-income workers' share of cost does not deprive them of funds needed for other essentials, which would potentially degrade their health status.

Employers also need their contributions structured according to ability-to-pay. Requiring health coverage would increase the labor costs of firms that do not now provide health insurance. A substantial hike in labor costs may reduce employment, either through cutbacks in the number of workers employed by some firms and/or through increased failures of vulnerable firms. Life expectancy for small firms tends to be much shorter than for larger firms; the closure or "death" rate of firms is inversely related to their size.¹⁴ Uninsured workers are disproportionately employed in industries that include many vulnerable firms. If employer contributions are not progressively structured, the increased burden on employers may cause economic dislocation, some increase in unemployment, and a reduced standard of living for those affected.

The combination of low wages paid to uninsured employees and the vulnerability of many of their employers would require substantial subsidies to workers and employers alike -- if we expand the employment-based system of health insurance coverage. Necessary subsidies may be a sizable contribution to the state budget, adding to the difficulties of enacting such a reform at the state level in the current fiscal and political climate. Moreover, given the current system of paying providers, the added health spending generated by such expanded coverage would fuel the flames of the medical cost spiral.

Such limitations may make universal health insurance through a public program (like Medicare) a more attractive alternative to expanding existing private job-based arrangements. Universal public medical insurance programs have been shown to have superior ability to control health expenditures. This approach, which separates eligibility for coverage from employment, has the additional advantage of creating a universal base of support, thus offering some assurance of equitable access for the poor and other politically weak groups who are not well protected in separate public programs. The same considerations may make this a preferable alternative also to some competitive approaches that would leave low-income populations in the undesirable, bottom tier of health plans. These advantages may offset the political disadvantages of placing more of the costs of financing health services on government budgets and the necessity of increasing public revenues. Still other approaches could be based on choice among competitive health plans and keep the added financing largely out of the government, but at the same time separate

¹³ *Closing the Gap*, Report to the Los Angeles County Board of Supervisors by the Task Force for Health Care Access in Los Angeles County, November 24, 1992.

¹⁴ Small Business Administration, *The State of Small Business*.

coverage from employment, give vulnerable populations access to the same coverage and health plans as more affluent groups, structure contributions according to ability-to-pay, and effectively control costs.

Whatever approach gains sufficient consensus, California's health care problems clearly require a national solution. Any solution also clearly must provide both universal coverage of the population and effective control of costs if it is to meet the needs of Californians and other Americans.

Mr. ANDREWS. Tell us, what is unique to California, what is unique about California's problems, that you would consider in trying to formulate a national policy?

Mr. BROWN. I think that the experience with competition in California in my view has been one of individual payers seeking their own solutions in the marketplace, and I think that the evidence that we have so far is that while that has worked in the short run for some payers at different times, overall, the effect has not been a salutary effect.

We have not seen any effective control of the rate of increase in our health care spending in California over time, and even those individual payers have really only been able to ratchet down, often on a one-time basis, a rate of increase in costs through a contractual arrangement. But nevertheless, the underlying factors have not been addressed, and their ability to control spending when they represent only a very tiny fraction of the entire market for health services I think has been very limited.

So in my view, I think at least in the area of health care spending, we have seen very limited effectiveness of these efforts by individual payers to get a handle on—

Chairman STARK. So competition is a bad thing?

Mr. BROWN. No, I think not. Not that competition itself is bad. What I would argue is that competition, without an overarching all-payer system within which that takes place, leaving each payer on their own in the marketplace, that I believe is bad.

I think that competition may be useful, depending on the level in which that competition is used in trying to control spending.

Mr. ANDREWS. To what factor does the worsening economy in California add to these costs? How significant is that?

Mr. BROWN. Well, the worsening economy limits the State's ability to pick up the slack of people who are left uninsured because they have lost their jobs, due to the economic conditions. That has been a severe blow to providers of care.

In many cases that means that some providers have to raise their costs to those with insurance, but at the same time that is difficult because of the contractual pressures that they have.

Mr. ANDREWS. I did not hear all of Mr. Salisbury's testimony, and I apologize for being on the floor when you testified. But the experience of competition in your region has been a plus in holding down costs, is that right?

Mr. SALISBURY. I am attributing that General Electric, Procter & Gamble and others say in Cincinnati, say that in that marketplace it has had that effect. I think most of the research one can look at vis-a-vis cost in California would tell you that it has had some positive cost effect in California, which is I guess I would say somewhat

different than the issue of the impact of competition on the balance of insured and uninsured individuals.

If you look at the historic data, it is interesting to note that even going back to 1988, which is really pre—the worse part of the recession out there, the uninsured population in California by the CPS numbers was 20.6 percent of the population. It then reached a high in 1990 at 22.1 percent of the population and fell slightly this last year as of March to 21.7 percent.

So California, because of some of the demographic factors the doctor has been talking about, the rate of noninsurance in California has been higher for quite some time than the national numbers. That doesn't say it is good or bad, it is just—it is a unique State because of some of the Latino and other factors he is talking about.

Mr. ANDREWS. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman. Well, Mr. Salisbury, after your interesting rebuttal of Dr. Vladeck's remarks, I am tempted to go back and read the transcript of that meeting.

Mr. SALISBURY. It was a clarification, not rebuttal.

Mr. GRANDY. Thank you. Let the record show that that is a clarification.

I want to know, if your testimony when you make your point about a tax-based reform, a tax cap specifically, being regressive on lower income employees, you must clearly be talking about a dollar amount, not a basic benefit package, the substance of which might be assessed at a certain amount which would be available to all and beyond which either an employer or an employee or both would be taxed; right?

Mr. SALISBURY. Even with a basic benefit package you could, in theory, get the same result, depending on the other aspects of your reform.

For example, one of the points that Dr. Swartz made is the aspect of the market that in experience rating and risk adjustment that is predominant now in the small business sector is the age rating of premiums. So that a given employer, small employer for a benefit package might pay dramatically different premium rates, for example, depending on the age of the individual.

So for a common benefit package, as long as age rating is allowed, you could readily have the situation where that same identical benefit package for the low income individual who happens to be age 57 has a premium of \$8,000 per year, compared to the high income individual who is much younger, that premium could be \$2,000 per year. If your tax change says, whatever the value of the basic benefit, it won't produce taxable income, there would be no regressive effect.

But frequently what individuals have been talking about is a dollar cap, if you will, rather than the benefit. And if you use a dollar cap in the absence of some additional reforms, you could end up with a significantly regressive effect.

Mr. GRANDY. I agree with that point. I think, and I have only been on this subcommittee a matter of days, but having been on the full committee for a couple of years now, I don't think the intent anywhere among policymakers involved in the details of this

would a cap on benefits be allowed that didn't involve this kind of switch from experience to community rating.

If you looked at some of the bills that were introduced last year by Mrs. Johnson and myself and others, there was a clear shift, not necessarily to community rating as it might have been defined in the 1950s, but to a less experience-rated model. The problem, of course, with that is that everybody else's premiums would go up as you include those higher risk and heretofore uninsurables in that universe.

That is an acceptable risk and a cost that I think a lot of us can live with. I just wanted to clarify, the tax cap is not regressive if you do add these modifications; isn't that—do I hear you say that?

Mr. SALISBURY. Dependent on how you structure it and dependent on your definition of regressivity.

For example, let's say that you have done the basic benefit, and for two individuals, because of that, it produces \$1,000 in additional taxable income. If because of the progressive tax structure your definition of progressive is that the higher income individual pays more absolute dollars in additional tax, then it is not regressive.

If, on the other hand, your evaluation is the proportion of that individual's income that is going to the payment of taxes, then it is regressive. And so it really does depend on how you look at the numbers.

But any way you cut it, \$200 in additional tax for the \$20,000-a-year worker is harder to afford than \$400 in tax for the \$100,000-a-year worker. And in that sense, that tax cap producing \$1,000 in additional taxable income for each individual would, in fact, have a regressive effect.

Mr. GRANDY. Factor in now the self-employed individual who at this point can effectively only deduct 12.5 percent, because the extender expired as of June 30.

Mr. SALISBURY. That is right.

Mr. GRANDY. Assuming we went back to a tax cap that was based on a community rating type of benefit package, that person is clearly advantaged, right?

Mr. SALISBURY. I would agree.

Mr. GRANDY. So in a sense that would change the numbers a little bit, too, because that person who has been left out of the mix at this point is now included, so that we do at least strike a blow for equity at that point, wouldn't you say?

Mr. SALISBURY. I would agree with that. We have run through our model about 42 different tax cap options with different types of phaseins and phaseouts. And the only point I make is there are clearly ways to design a tax cap and have it not be regressive by any measure. It is only if you do it on a very flat basis applicable to everyone that you do, in fact, produce some of a regressive effect.

Mr. GRANDY. OK. I appreciate that point and I will end on that. Thanks, Mr. Chairman.

Mr. ANDREWS. Mr. McCreary.

Mr. McCREARY. Dr. Swartz stated in her testimony that—I think, when all are insured, it will be easier to control costs. Did you say that?

Ms. SWARTZ. I did.

Mr. McCRERY. And I thought I heard Dr. Brown say in California, if you simply expand the universe of people in California who are insured, you exacerbate the cost problem.

Mr. BROWN. That is only if we do not do anything to address the cost problem directly.

Mr. McCRERY. Right. If all you do is add insurance coverage, then you exacerbate the pressure on cost.

Mr. BROWN. That is correct.

Mr. McCRERY. How do you all reconcile those statements, or do you?

Ms. SWARTZ. Well, what I was saying was that I think that the goal of controlling the growth in health care costs is absolutely the most important domestic problem that Americans seem to believe is there. But that to believe somehow that there is a tradeoff and that if we control the increase in health care costs without addressing people without health insurance, to me that is missing the point.

We must deal with the fact that a lot of people are very worried that they too will lose their health insurance or that they will have a period of time when they won't have health insurance, or the particular conditions that they have will not be covered by their employer-provided health insurance. We have to address those needs, those concerns, and that if you do that in conjunction with controlling health care costs it will be much easier, because everyone in this country will then have a stake in controlling the health care costs.

Right now it is as if, well, we don't have to deal with these people without health insurance, they are our safety valve, and I don't agree with that.

Mr. BROWN. May I comment also, Mr. McCrery?

Mr. McCRERY. Please.

Mr. BROWN. I believe that if we do not provide coverage to the presently uninsured population, it will make it more difficult to control health spending for two reasons: First, simply economically, we will not be bringing the health spending for that population within some kind of regularized framework of private insurance and public oversight. And therefore, that spending, falling outside, will not be channeled or directed into appropriate, more efficient kinds of provision of health services.

But secondly, I think there would be a social cost and I think that is what Dr. Swartz was referring to, that will be unacceptable to Americans. I know, from our experience in California as well, that we would simply be pushing those people into an arena in which they could get no care. Right now their care is provided either by public providers at taxpayer expense or by private providers with some cost shifting, and the point I was making about California is that that has become exceedingly more difficult in recent years because of managed care kinds of arrangements and their growth in the State.

Mr. McCRERY. And Dr. Brown, you went on to talk about how individuals in California who are responsible for their own health care bills, constitute only a very small percentage of the population, and that—that their impact on costs has not been noticeable at all, that they have not—that individuals paying for their own

health care have not been able to effect downward pressure on health care costs.

Mr. BROWN. I think perhaps I was not clear. What I meant by that was that each payer, by which I meant each employer, each health plan or Government program has individually attempted to control their own costs. I was not referring to individual payers in that respect. And yes, I agree with Mr. Salisbury, in certain areas of increased competition—for example, where there is greater competition impinging on hospitals—that the combination of competing hospitals and pressure from payers seeking discount rates has kept the growth of health care spending below the level of other areas where there is less competition in that respect.

But I think that some of that has really just been a capping at the hospital level, but not necessarily a control of growth outside the hospital level. In fact, we have seen, of course, as in the Medicare program, substantial shifting of services away from those kinds of capped or contractual limitations on expenditures or prices or rates to areas where there are no such caps. And where providers have, in fact, increased volume and increased their take.

Mr. McCRERY. Thank you.

Mr. ANDREWS. Mrs. Johnson.

Mrs. JOHNSON. Thank you. I am sorry that I missed the panel's testimony, but I am pleased that I got here to raise an issue that I just want to hear your comments on. I am very interested, as you undoubtedly know, in insurance reform. I don't consider it the answer, but I consider it one of the changes that has to be made to restructure health care to both control costs and eventually position us to assure universal access.

But in the insurance reform area, there is going to be the challenge of constraining rate growth, whether you go as far as community rating or whether you just constrain variability. This will be an important issue.

And if we deal with it wrong, we could make the whole reform effort of little consequence to us. So I am interested in it. But the particular aspect of that issue that I want to raise with you is the question of variable premiums, and the power of variable premiums to promote healthy behavior.

If we do anything in health care reform, we have to in part control costs by getting people more involved in their own wellness, and early diagnosis, and participation in difficult decisions like end-of-life care. So this isn't certainly the answer, but I think premiums that differentiate between smokers and nonsmokers are still a valuable tool in—as part of health care reform, and I think that as we get further along in research into wellness and prevention, we will find other things that are within a person's control that contribute to low-cost health insurance and ought to be reflected in premium costs.

So that I want to maintain the lever of variable premiums for wellness actions. But at the same time, I want to constrain the variation in premiums for underwriting purposes by the insurers.

To what extent have any of you studied the use of—I mean the most common one right now is the variable premium between smokers and nonsmokers. I think the concept has some other applications, but that is the only one I am aware of, the only circum-

stance in which that differential is used, and I just wonder what knowledge you have of that kind of an issue and what you think of it as a part of the solution in the future.

Ms. SWARTZ. If I could respond to that, I would like to. First of all, I believe quite strongly that we should look at a person's lifetime in terms of whether the person is a high risk or a low risk in terms of levers to apply to this person's variability. But it makes very little sense to me to look at a person's risk in a particular year.

If you look at most people over their lifetime they will have high medical expenditures perhaps in the first couple of years and then they go way down and they only start climbing again once the person is past age 45. And one thing that has happened over the last decade, 15 years, is that somehow this country has gotten into "me first and not us as a community."

And I really do believe that we should have community rating where we look particularly at a person's medical expenditures over a lifetime, not in a particular year or time period—short period of time, which brings me to my second point.

I agree with you that you want to maintain some leverage over the kinds of behavior that lead to healthier lifestyles or healthier longevity, and that smoking is the particular example which seems to work. That if we charge higher premiums for somebody who smokes, that makes sense. It is like saying to somebody if you put a smoke detector in your house, we will give you a discount on your fire insurance or your home insurance.

By the same token, most other medical expenditures that we have related to chronic illnesses are not something that I think people can live healthier lifestyles for. People I know who have died of cancer already were nonsmokers. These are people who lived what I would call healthy lifestyles, and I think of these as random acts of God that happened.

The same thing happens with people who have multiple sclerosis, muscular dystrophy, any of the other chronic conditions that you can mention.

Mrs. JOHNSON. Except that I would point out to you that in every social service agency that I have ever visited in all of the towns that I represent, I have had pointed out to me repeatedly that in every family they treat, substance abuse is a big issue in 80 percent of the cases. So substance abuse, tobacco, overweight and under-exercise, those are measurable things, that if we develop this approach sufficiently, we ought to be able to check on whether people are in fact doing what they say.

Ms. SWARTZ. I agree, but I am afraid of blaming the victim, and I think that there is this perception right now that people who develop cancer or one of these other chronic conditions are somehow at fault and I don't think they are at fault.

Mrs. JOHNSON. They are also a modest part of the health problem in America, and if we don't get at some of the systemic causes, I hear your point.

Ms. SWARTZ. They relate back to what I was talking about with self-insured firms that are allowed no longer to cover medical expenditures of employees or dependents who have those conditions,

and that is what I think is the real warning. It is in my testimony that you didn't hear.

Mrs. JOHNSON. I will go back over it.

Ms. SWARTZ. One last point. I think that we could, in fact, along with having levers in terms of variability on the premium, you could come at this in another direction, which is that we would see a higher deductible perhaps for somebody who comes into a hospital or a physician with an accident-related medical expenditure where they did have some control over the risks that they were taking. We do this in life insurance.

People are not insured if they are hang gliders or fly gliders and it seems to me that we could do the same thing here. The number of people who have sports injury-related medical expenditures is something I don't think we have a clue about right now, or what percentage of our medical expenditures are due to things which are risky like roller boarding and skate boarding.

Mrs. JOHNSON. Thank you.

Mr. BROWN. May I just respond?

I certainly agree with your sentiment about wishing to provide incentives for people to adopt healthful behaviors and eliminate or avoid health damaging behaviors. And as a past president of the American Cancer Society in Los Angeles, I certainly have a lot of sympathy for almost any action to discourage people from smoking.

But I think that there are other measures that are much more effective than the use of variable health insurance premiums to affect that kind of behavior. We know, for example, that raising the price of a pack of cigarettes through added taxation discourages, especially young people, from taking up smoking, and that is useful. Restricting advertising campaigns and the like are also useful.

Also providing more education and more opportunities for people to engage in exercise and more encouragement to do so, more effective kinds of weight control programs. I think the problems of obesity are not easily addressed through variable insurance premiums when we really don't have effective measures to help people reduce their weight, so that we may in fact simply be adding stress, as well as financial cost, to people who already may have a weight problem in part because of some kinds of stresses in their lives that for them an eating disorder is a response to.

So I think we need to find a lot of effective ways to change behaviors, primarily in my view through education and a variety of tax incentives. But I fear the consequences of using health insurance premiums as a way to do that, when we may in fact be discouraging coverage for the very people who actually need it the most and through whose coverage we can mandate managed care plans and indemnity plans to provide coverage for those kinds of service and education programs and the like.

Mr. SALISBURY. Congresswoman, going to the other piece of your question, just on the research issue though, I just finished involvement with an Institute of Medicine study and one of our frustrations was that the ability to document very extensive current use of wellness and health promotion approaches, including building it into premium values, there is a tremendous amount of information

on what is being done. There is a near total dearth of analysis yet quantifying the effects of those experiments.

Much of it is relatively recent. The employers doing some of these things most aggressively believe that they are getting results, but even those individual companies when we went to them are yet to get to the point where they have quantified much of it.

Mrs. JOHNSON. I see.

Mr. SALISBURY. The second footnote I would add, you had used the drug abuse issue, is on a number of these issues, and mental and drugs is one of the fastest growing areas of medical expense, is a prime example of an area where most of that expenditure is attributable to dependents and goes particularly to children of the insured, and generally it only becomes known not at the point that they are engaging in the activity, if you will, but at the point that suddenly treatment is needed.

I think one of the other things coming up in these areas is the degree to which you really, in the most important areas, like—or the most important cost areas like mental and drug, whether you even have the ability to build in prevention, and even though it might have a desirable effect.

Mrs. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Mr. ANDREWS. Thank you, Mrs. Johnson. The hearing stands adjourned.

[Whereupon, at 1:45 p.m., the hearing was adjourned.]

[Submissions for the record follow:]



Coalition on Smoking OR Health

STATEMENT OF THE COALITION ON SMOKING OR HEALTH ON HEALTH CARE REFORM

Mr. Chairman:

The American Cancer Society, the American Heart Association, and the American Lung Association, united as the Coalition on Smoking OR Health, appreciate the opportunity to share with you our views on the importance of prevention in the overall scheme of health care reform. We believe that no serious effort to achieve health care reform in this country can be achieved without addressing the issue of tobacco use.

Probably the most effective way to control costs in the health care system is to prevent disease and disability in the first place. The single greatest preventable cause of death and disability in the United States is tobacco use. Every day approximately 1200 Americans die from a tobacco-related disease, including lung cancer, heart disease, emphysema, chronic obstructive lung disease, and stroke. The leading cause of cancer death in both men and women - lung cancer - was a medical rarity in 1923 before the effects of the upsurge in tobacco use began showing up in large numbers of people. The dollar cost to our society each year from the death and disease associated with tobacco use is estimated to be \$65 billion, but the toll in misery and pain to the victims and their families and friends is incalculable. And is totally preventable.

The destructiveness of tobacco does not end as the victims die, for new victims are waiting in the wings. Each day about 3000 children will try cigarettes for the first time. These new smokers are tragedies waiting to happen. The children who experiment today are at high risk to become addicted to this product and fall victim to its disease-causing characteristics.

Tobacco is the only legal product which, when used as intended, will cause death and disease. If cigarettes and other tobacco products were invented today, they would most likely not be allowed to be sold. Like any new consumer product, cigarettes would be subject to government regulation. That tobacco products pre-date regulation of consumer products is an historical accident which need not be perpetuated. They should be subject to federal regulation. Nonsmokers should be protected from environmental tobacco smoke emanating from other people's cigarettes. Excise taxes on tobacco products should be raised to a level which would discourage initiation and continuation of tobacco use. A major commitment to these steps would do much to mitigate the damage done by tobacco and control the costs of health care.

Regulation of tobacco products includes manufacture, distribution, sale, labeling, advertising and promotion. At a minimum, Federal regulation of tobacco products should require the Food and Drug Administration (FDA) to:

- Apply the same regulatory standards to the advertising and promotion of tobacco products that it does to other legal prescription drug products (particularly other nicotine containing prescription drugs);
- Require that all additives which are added to tobacco are tested for safety in a comparable manner to the way additives used in foods are tested;
- Require that the product is fully labeled to provide the public with complete and adequate information on additives, constituents (i.e. benzene, arsenic) in tobacco smoke; additional warnings such as addiction, increased risk of stroke and the effects of environmental tobacco smoke on nonsmokers; other contraindication warnings such as increased risks for persons with preexisting medical conditions, use of tobacco with birth control pills, etc.;

- Use its authorities to ensure enforcement of federally mandated minimum age of sale and dispensing laws;
- Prohibit the use of implied and or direct health claims for tobacco products (i.e. low tar, low nicotine) which have not been substantiated;
- Use its existing authorities to regulate tobacco products under its drug authorities when advertisements, labeling, or other promotions for these products make explicit or implicit health claims.

Tobacco products readily fall into the hands of children because of a lack of government controls and enforcement mechanisms. All but two states have some restrictions or prohibitions on the sale of cigarettes to minors. Nonetheless, tobacco products remain readily available to young people because of virtually nonexistent enforcement efforts, unrestricted free sampling, the availability of tobacco products from vending machines, and the paucity of rules and regulations designed to discourage tobacco sales to underage young people. National leadership is needed to provide a consistent and effective way to control access by youth to tobacco products.

A good start on the necessary leadership would include:

- enforcement of the Synar amendment to the ADAMHA Reauthorization Act, which requires states to enforce their age restriction on the sale of tobacco products or lose a portion of their block grant funds; and
- enactment of bans on free sampling, sale of tobacco products through vending machines, and licensing requirements for sellers of tobacco products.

In 1990, the last year for which data is available, the tobacco industry spent \$3.9 billion on advertising and promotional activities. These activities by the industry overwhelm the efforts of the public and private sector to educate this nation's youth about the health effects of tobacco; create a climate that increases peer pressure on young people to use tobacco; and, trivialize and diminish the significant health hazards of tobacco use. The Coalition recommends the following steps to diminish or eliminate the harmful effects of tobacco industry advertising:

- enactment of legislation to prohibit all tobacco advertising and promotional practices.

In the absence of a complete ban on advertising, the following can be considered as interim steps:

- limiting tobacco advertising to tombstone advertising, with text only and no representation of humans;
- banning brandname promotional practices, including sponsorship of sporting events, concerts, jazz festivals, and the like, which include the use of product names and logos;
- enforcement, through regulation or other means, of the provisions in the industry's so-called "voluntary code"

Other needed actions dealing with advertising include:

- enactment of legislation to limit or eliminate the taxpayer subsidy of advertising and promotion expenses through the business tax deduction;
- regulation of health-related claims of tobacco advertising; and
- repeal of the federal preemption on state regulation of tobacco advertising, which limits states' ability to enforce their deceptive acts and practices statutes.

Scientific evidence is mounting that non-smokers are adversely affected by exposure to the toxic smoke produced by other people's tobacco use. The Environmental Protection Agency in the recently approved risk assessment called "Respiratory Health Effects of Passive Smoking," estimates that 3000 lung cancer deaths per year in non-smokers are caused by environmental tobacco smoke. According to the American Heart Association, ETS is also responsible for between 35,000 and 40,000 deaths yearly in the U.S. from cardiovascular disease. Young children are not immune to the effects of ETS. The EPA estimates that exposure to parental smoking is responsible for 150,000 to 300,000 lower respiratory tract infections per year in children under 18 months of age, with about 7,500 to 15,000 hospitalizations. Exposure to ETS exacerbates and aggravates symptoms in children with asthma. There is some evidence that ETS exposure also causes asthma in children who have not had the disease previously.

The Coalition believes that a major effort at prevention of disease must include enactment and enforcement of legislation and regulations to reduce the exposure of nonsmoking adults and children to environmental tobacco smoke, with emphasis on facilities and activities which expose the greatest number of people to ETS for the longest periods of time, such as workplaces, schools, daycare centers, and healthcare facilities. Possible mechanisms include:

- comprehensive clean indoor air legislation;
- legislation banning smoking or requiring no smoking policies in selected federally funded programs or facilities; and
- regulatory action by the Occupational Safety and Health Administration (OSHA), provided such action allows continuation of existing state and local restrictions which are at least as comprehensive as federal action.

One action which can both reduce the incidence of smoking in this country and provide a source of revenue to finance a comprehensive health care reform initiative is a major increase in the tobacco excise tax. Excise taxes have an enormous potential to rapidly and significantly reduce smoking among teenagers and adults. For every 10 percent increase in the price of tobacco products, there will be approximately a four percent decrease in tobacco consumption, and possibly an even greater decrease in tobacco use among children. For example, a tax increase of \$2 per pack is likely to reduce tobacco use by about 23 percent and encourage more than 7 million Americans not to smoke, preventing about 2 million premature deaths over time.

Federal, state, and local governments currently collect about \$11 billion dollars in cigarette excise taxes. Of that total, approximately \$4.75 billion is the federal share. The revenue potential of the tobacco excise tax is significant. The Coalition estimates that an increase from the current 24 cent per pack federal tax to \$1 would raise an additional \$20 billion, and an increase to \$2 would generate an additional \$35 billion.

The relatively small increases in the excise tax over the last decade have not kept pace with the tobacco industry's own price increases. In constant dollars, the federal excise tax on cigarettes is about one-half what it was in 1955. In contrast, the retail pack price is approximately seven times what it was in 1955. The 1955 tax was almost half the retail price. The 1991 tax is just over 25% of the retail price.

Tobacco excise taxes in this country are substantially lower than in virtually all other industrialized western nations. Our neighbor to the north, Canada, has raised combined federal and provincial taxes from an average of 46 cents per pack in 1980 to \$3.27 in 1991. The payoff in revenue increases and consumption decreases has been dramatic. Revenue has grown about sevenfold and per capita consumption has dropped by about 40 percent.

The Coalition strongly recommends that the Congress and the Administration enact a major increase in the excise tax of \$2 per pack to provide both significant health benefits and revenue to be used for health care or other purposes.

In conclusion, the Coalition on Smoking OR Health believes that any meaningful reform of health care in the United States must seriously address prevention issues. One of the biggest advantages to be gained from prevention will come from addressing and reducing tobacco use. The current use of tobacco is one of the most significant causes of death and disease in this country. We propose addressing the problem of tobacco use in several ways. Tobacco products should be subject to federal regulation. Nonsmokers should be protected from environmental tobacco smoke emanating from other people's cigarettes. Excise taxes on tobacco products should be raised to a level which would discourage initiation and continuation of tobacco use. These steps would do much to advance the cause of health promotion and disease prevention and control the costs of health care.

AMERICAN SOCIETY OF CLINICAL ONCOLOGY

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The American Society of Clinical Oncology (ASCO), representing some 9,000 physicians engaged in clinical practice and research, looks to the national debate on health care reform as a forum to address many long-standing problems facing cancer patients and survivors. We thank you, Mr. Stark, and the Committee on Ways and Means for the opportunity to highlight these issues which have such a significant impact on people with cancer.

Clearly, the country is beginning to accept the challenge of reforming our health care system. The economic recovery of the country as a whole and the welfare of individual citizens are viewed by many as dependent on substantial reform of both health care delivery and third-party payment. However, as we address these goals of expanding access and restraining costs, the cancer community is concerned that the reforms we adopt maintain quality of care. Health care reform will only be successful to the extent it achieves a balance among these three factors -- access, cost-control, and quality.

Impact on Cancer Patients

Each year, over 1 million Americans will be diagnosed with, and 500,000 people will die from, cancer. Fifty percent of these diagnoses occur in people over the age of 65. Soon cancer will overtake heart disease as the leading cause of death. By the end of this decade, cancer will account for more than 20 percent of health care expenditures.

In light of these statistics, perhaps it is not surprising that cancer treatment is often regarded as inherently not cost-effective and thus a favored target for restraining either the scope of services or payment amounts for those services. Yet, we must not lose sight of the fact that cancer therapy -- whether curative or palliative -- is improving. In recent years, the overall relative five-year cancer survival rate has improved from 38 to 52 percent.

Health care reform must recognize the needs of the 8 million Americans now living as cancer survivors. People with cancer suffer disproportionately from the deficiencies in the present health care system. The problems encountered by those currently or formerly diagnosed with cancer include:

- discrimination on the basis of health status against individuals diagnosed with cancer or their family members to prevent them from obtaining insurance;
- use of preexisting condition clauses to restrict unfairly the extent of coverage for those able to purchase insurance;
- pricing policies for insurance based on experience rating rather than community rating, which unfairly penalizes small groups and subjects people with cancer to potential job discrimination;

- exposure to catastrophic out-of-pocket expenses because insurance coverage is inadequate; and
- arbitrary denial of coverage for cancer treatment involving either unlabeled indications of drugs approved by the Food and Drug Administration (FDA) or investigational therapy given pursuant to a clinical trial.

Virtually any approach to reform likely to receive serious consideration will address many of these problems, including discrimination, preexisting conditions, pricing and rating practices, and maximum out-of-pocket expenditures. However, there is not cause for similar optimism concerning the nature and extent of coverage for cancer treatment to be offered in any reform proposal.

Considerations for Health Care Reform

In a reformed system, benefits for cancer treatment must be at least as comprehensive as those in the Medicare program. This includes coverage for services (including drugs used as part of an anticancer regimen) provided incident to a physician service. However, to ensure access to high quality care, these benefits must be expanded to include explicit coverage for drugs prescribed for indications not specified on the Food and Drug Administration (FDA) label as well as for patient care costs associated with participation in clinical trials. Optimally, coverage should also be extended to outpatient drugs, prevention services including health education, and diagnostic screening for diseases like cancer that are more readily treatable if diagnosed early.

Furthermore, the reformed system must ensure every individual with cancer access to a trained oncologist or other specialist in the treatment of that disease. To the extent that managed care is part of the health care reform solution, every plan should be required to provide adequate oncology and other specialty services.

Unlabeled Indications of FDA-Approved Drugs

Modern oncologic practice requires the frequent use of drugs for indications other than those specifically approved by FDA. Somewhere between one-half and three-fourths of the uses for anticancer drugs involve these so-called unlabeled indications. Oncologists inform themselves of the best treatment for their patients not by consulting the drug labeling endorsed by FDA, but by reference to standard medical compendia and to the medical literature, which in the field of oncology is constantly being updated to recognize new therapies based on existing anticancer agents.

FDA itself has always recognized the physician's prerogative to use approved drugs in ways other than contemplated on the label. In a 1982 Drug Bulletin, FDA stated that the Food, Drug & Cosmetic Act "does not...limit the manner in which a physician may use an approved drug." Moreover, "[once] a product has been approved for marketing," according to the agency, "a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling." This view has been supported by the Health Care Financing Administration (HCFA), the National Cancer Institute (NCI), and the Institute of Medicine as well as national representatives of

the insurance industry.

Coverage for unlabeled indications was studied extensively by the National Committee to Review Current Procedures for New Drugs for Cancer and AIDS (the "Lasagna Committee"), appointed by then Vice President Bush. The Committee recommended coverage of unlabeled indications where such uses are listed in one of the three medical compendia¹ or otherwise supported by the medical literature.

In response to the Lasagna Committee report, both the Health Insurance Association of America and the Blue Cross/Blue Shield Association have liberalized their positions on this issue. In addition, the Medicare program has long pursued a policy, as reflected in the Medicare Carriers Manual, of permitting coverage of unlabeled indications, particularly in the area of cancer treatment. Yet, despite what appeared to be consensus regarding coverage of unlabeled indications, many private insurers as well as several Medicare carriers have refused payment for unlabeled indications on the spurious ground that such uses are "experimental," "investigational," or "not acceptable medical practice."

Lack of standard coverage for unlabeled indications of drugs used as part of an anticancer regimen has severe negative consequences for patients and physicians alike:

- First, patients are deprived of the best available care, which often involves use of unlabeled indications.
- Second, refusal to cover unlabeled indications inhibits dissemination of new therapies which not only may improve the patient's chance for survival but also pave the way for future advances.
- Third, at least some opportunities for cost savings are lost when carriers refuse to pay for new products or new indications which may in fact be more cost-effective than older alternatives.
- Fourth, physician and office resources are wasted when unlabeled indications which should be routinely reimbursed require substantial effort to have payment recognized.
- Fifth, drugs represent a significant out-of-pocket expense for both patients and physicians, so that nonpayment for them is more problematic than a simple refusal to cover other physician services.

Several recent studies conducted by the General Accounting Office (GAO) have demonstrated the severity of this problem. In September 1991, GAO released the results of a national survey concerning reimbursement for unlabeled indications.² More than half of the respondents indicated

¹ American Hospital Formulary Service, U.S. Pharmacopeia -- Dispensing Information, and the American Medical Association Drug Evaluation.

² In February 1991, initial results of the survey were published.

reimbursement problems during the previous twelve-month period in connection with use of an anticancer drug for an unlabeled indication.

A follow-up study, requested by the Senate Finance Committee, was published in July 1992. In this survey, GAO examined the impact of reimbursement decisions on the setting and cost of chemotherapy administration. GAO observed that some patients are receiving care in hospital settings when, by clinical standards, treatment could have been provided in the office and that financial factors are influencing the choice of treatment setting. GAO concluded that Medicare reimbursement policies for unlabeled indications may negatively affect "where a cancer patient gets treatment and, as a result, Medicare costs for that patient's care."

To resolve this problem, carrier discretion in this area must be curtailed and national policy adopted to ensure all cancer patients access to state-of-the-art treatment. This policy must affirmatively require carriers to reimburse unlabeled indications of FDA-approved agents when such uses are referenced in one of the three authoritative medical compendia or otherwise supported in the peer-reviewed medical literature.

Patient Care Provided in Clinical Trials

Substantial progress in treating cancer has been made over the course of the past two decades through clinical research. Patient enrollment in clinical trials not only enables this progress to continue, but also provides access to the best available care to people with cancer. In recent years, however, many third-party payers -- including the Medicare program -- have targeted clinical research as a means of controlling costs. Many insurers will deny coverage for patient care costs involved in clinical trials even though the care is probably superior to that which would have been received off protocol, particularly in the treatment of cancer.

A January 1989 report³ submitted to the Senate Appropriations Committee by the National Institutes of Health emphasizes this point:

"NCI does not consider the research exclusion justifiable. For patients with life-threatening diseases for which standard therapy is inadequate or lacking altogether, participation in well-designed, closely monitored clinical trials represents best medical care for the patient. The NCI believes that clinical trials are standard therapy for cancer patients to whom a curative therapy cannot be offered...For these reasons, we consider it appropriate for third-party carriers to reimburse patients for medical care costs of participating in scientifically valid clinical trials."

3

Raub, William F. "Remedies and Costs of Difficulties Hampering Clinical Research." Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute. January 1989. (Report submitted to the Senate Committee on Appropriations in response to Senate Report No. 100-399.)

It is critical that any health care reform proposal include, as part of the minimum benefits requirement, provision for reimbursement in connection with care provided in clinical trials. By doing so, a reformed health care system can encourage advances in medicine and evaluate the relative outcome and effectiveness of treatments. At the same time, this coverage policy would allow desperately ill patients access to optimal care, regardless of their ability to pay.

To ensure access to high quality cancer care, the cost of medical care provided when a patient is entered on a Phase I, II, III, or IV (post-marketing) clinical trial -- including hospital, physician, and other health care services as well as the cost of approved agents for labeled or unlabeled uses which might be part of the regimen -- should not be denied coverage and reimbursement when all of the following are demonstrated:

- Treatment is provided with a therapeutic intent;
- Treatment is being provided pursuant to a clinical trial which has been approved by the National Cancer Institute (NCI), any of its cancer centers, cooperative groups or community clinical oncology programs; the Food and Drug Administration in the form of an investigational new drug (IND) exemption; the Department of Veterans Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;
- The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;
- There is no clearly superior, noninvestigational alternative to the protocol treatment; and
- The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the alternative.

Coverage policy based on these standards would strike an appropriate balance for any third-party payment system because it recognizes that therapy which has not been definitively established as the standard of care should be reimbursed only in a carefully controlled context where ethics, potential effectiveness, and contribution to medical progress are taken into account. This position is supported not only by the physician and research community but also by patients and survivors of cancer as represented by the National Coalition for Cancer Survivorship (NCCS), the largest nationwide consumer group speaking on behalf of people with all kinds of cancer.

* * * * *

The debate on health care reform has, to date, centered on access and cost-containment. While these factors are essential, attention must also be given to the impact of a new system on our ability to deliver the best available care. Cancer

patients and others with serious and life-threatening diseases deserve access to state-of-the-art treatment. We can greatly facilitate achievement of this goal -- as well as improve our ability to assess relative effectiveness of therapies -- by adopting national, uniform coverage policies for unlabeled indications of drugs used in an anticancer regimen and for patient care costs associated with clinical trials. Any system which omits these as minimum benefits will disproportionately deny cancer patients access to high quality care.



HEALTH CARE REFORM

Family Service America, Inc. (FSA), founded in 1911, is an international nonprofit organization dedicated to strengthening family life through services, education, and advocacy. As the oldest and largest network of community-based family counseling and support services in North America, serving more than 3.2 million people annually in over 1000 communities, FSA fully recognizes that every American family deserves access to affordable and quality health care, including mental health and preventive care services.

The United States spends about 40% more per capita than any other nation on health care costs. This year alone, the nation's medical bill will run to more than \$800 billion. For those who have access to it, American medical care is without parallel; it sets the world standard for quality care. Since 1980, however, the average cost of individual health insurance has risen from \$1,000 to \$3,000 a year. There are over 37 million people who are currently uninsured in our country, and an additional 100,000 are finding themselves without health insurance every month. Of the 35 million, approximately 13% of all children (8.3 million under age 18) and 9% of pregnant women (433,000 women) are not covered. Families without health care coverage are the most vulnerable.

Family Service America, Inc., therefore, considers immediate federal leadership in the development of a universal, family-centered, inclusive health care system as essential to the well-being of the country and its people. FSA believes that any comprehensive health reform should contain the following principles:

- easy accessibility and affordability to individuals and families in all socioeconomic strata, regardless of employment status and size of employer,
- provision of prevention, early intervention, diagnostic and treatment services,
- inclusion of emotional, mental health and substance abuse diagnosis, family services, and treatment,
- a definition of family as "two or more people, whether living together or apart, related by blood, marriage, adoption, or commitment to caring for one another,"
- recognition of family members as full partners with health care professionals, and families as primary health treatment providers and sustainers for children of all ages, parents, spouses, siblings, grandparents, and significant others, by financially supporting the constructive role of families in the promotion of healthy life-styles and supporting involvement in the prevention, care, and treatment of illness among family members,
- universal health care coverage that extends to all members of a family, not only the employed member, that is available, independent of preexisting conditions, and that assures cost controls and portability.

On behalf of America's families, Family Service America welcomes the opportunity to work with the Administration, Congress, the states, health care providers and other interested parties in the development of a health care system for the country that better serves all people.

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Home Medical Equipment and Services: Providing Preferred, Cost-Effective Health Care In the Home

I. Introduction

One of the most pressing issues to be faced by the 103rd Congress will be how to set the direction for our nation's health care reform — a precarious balance of maintaining quality of care and expanding its access, while reducing costs. Toward that goal, this paper addresses the potential role of home care in ensuring quality, affordable health care for all Americans. Home care using home medical equipment (HME) services can ensure the continued provision of high quality health care in a setting that the vast majority of patients and their families prefer. And, that care can save our nation's health care system billions of dollars. But it will not happen unless the new Administration appreciates the policy issues that will ensure growing access to home care.

As America addresses the difficult issue of health care reform, one potential part of the solution routinely has been overlooked: home care using HME services. Currently, there are approximately 5,000 to 8,000 HME suppliers, about 11,000 home health agencies and some 1,200 freestanding hospices providing home care services to millions of Americans. Home care services come in many forms, from life-saving equipment to specialized nursing care and financial management assistance for patients and their families. These services often can be more cost-effective than certain institutional care while providing as high a level of quality of care as hospitals, nursing homes and other facilities. Recent studies have found that a large majority of Americans believe that receiving treatment in the comfort of their own home when recuperating from an illness or injury would be vastly preferable to some form of institutional care. When reforming the health care system, home care and HME services should be included in any basic set of uniform benefits package that eventually is developed.

The future growth of home care services is being fueled, in part, by a powerful convergence of demographic, technological, economic and consumer trends. Each trend or "imperative" provides a unique contribution to creating an increased demand for home care services:

- The "Demographic" Imperative — creating the growing need for home care;
- The "Technological" Imperative — created by scientific and technological innovations that are enabling more Americans to choose home care options;
- The "Economic" Imperative — created by home care's fulfillment of the need for cost-effective health care services; and
- The "Consumer" Imperative — created by the public's preference for home care.

Taken together, these imperatives for growth present a compelling case for the overarching theme that home care services can and must play a key role in responding to the emerging health care needs of Americans and solving the current health care costs dilemma.

Manufacturers of HME are continuing to invest significant research and development resources in equipment designed to help the millions of Americans who have some type of condition that requires home care or "assistive" technology. In the recent past, similar efforts have led to the introduction of such devices as oxygen concentrators, portable oxygen cylinders, home infusion therapy equipment, lighter and stronger manual wheelchairs and state-of-the-art prosthetic devices. Congress should address these issues to ensure that home care makes the fullest possible contribution to guaranteeing health care quality, accessibility and affordability for all Americans.

II. The Provision of Home Medical Equipment and Services

A. HME Suppliers: Home Care Professionals

Home care services are provided by many different professionals and volunteers. Many patients seeking home care services for the first time may not be sure where to turn; they also may be unsure of how the home care process works. In addition to providing consumers with a clear understanding of the "who" and the "how" of their services, HME suppliers make concerted efforts to educate and support "caregivers." Demographic and life-style

trends (e.g., increasing geographic diversity and a growth in the number of working couple households) make it more and more difficult for traditional caregivers — who represent an absolutely vital link in the home care process — to care for loved ones.

HME suppliers provide the equipment, services, education and caregiver training necessary for the successful use of HME. They also provide follow-up service, repair and maintenance for HME. Patients or their families often choose the home care provider or supplier they prefer. In the case of immediate post-hospital care, however, that choice often is made by a discharge planner. In the case of non-hospital-related care, the choice of a home care provider or supplier may be made by the attending physician. Suppliers also train family members in the proper use of HME and provide 24-hour emergency service when needed. Many HME suppliers have nurses or therapists on staff who make home visits to monitor patients and equipment. HME suppliers also aid families in completing and submitting necessary paperwork to ensure appropriate insurance reimbursement.

The role of HME suppliers in the overall health care system has been misunderstood. For example, some consumers and health professionals mistakenly believe that, aside from follow-up maintenance calls, the responsibilities of an HME supplier begin when equipment is ordered and end when it reaches the patient's doorstep. In fact, that is only the beginning of a complicated, yet crucial process.

In many cases, "the HME company is actually bringing the hospital care home to the patient" — HME helps make homecomings possible. For that reason, the people who deliver HME must be highly trained in its operation, as well as the medical conditions being treated, to ensure that caregivers and patients operate equipment safely and effectively. These requirements complicate the HME process and often force the supplier to incur operating expenses that people outside the HME services industry may not recognize or acknowledge.

B. The HME Process

What follows is a step-by-step explanation of the HME prescription, delivery, maintenance and billing process:

Under the Medicare program, HME always must be prescribed by a physician. Once a physician determines that a patient can be treated at home, he or she may order appropriate equipment directly, but more often that duty falls to a discharge planner or social worker. The hospital discharge planner or social worker discusses specific needs with the patient and caregiver and makes them aware of the different HME suppliers in the area. *Once chosen, the HME supplier works closely with the discharge planner or physician's office to identify equipment that best meets the requirements of the patient.* Often, variables besides specific medical needs must be addressed. For example, a patient living on the third floor of a walk-up apartment building may need special or customized HME. Once these special needs are determined, equipment can be ordered. Phone orders are common, but all orders also must be verified in writing through a certificate of medical necessity (CMN) form that is completed and signed by the attending physician.

After the order for equipment is placed, *the HME supplier carefully checks insurance guidelines* to make sure that the prescribed equipment is covered, that the patient qualifies for home care benefits and that the patient meets all documentation requirements. In many cases, HME suppliers are required to contact the insurer prior to the beginning of treatment. After consultation with the physician and discharge planner, the supplier arranges a delivery time with the patient.

Delivery of HME is much more involved than delivery of other types of equipment for the home. Complicated or large pieces of equipment often cannot be carried en masse into a patient's home. Instead they may have to be assembled on site. This means a *delivery person must have extensive knowledge of the mechanical operation of the HME and the medical purpose it fulfills.* Furthermore, employees who deliver equipment are required to train patients and caregivers to ensure that they know how to operate the HME safely and effectively. Following installation and verbal training, *HME suppliers must provide detailed, written instructions for patients and caregivers* to refer to in the future. Suppliers also must carefully explain all paperwork related to the equipment, including warranty, patient rights and responsibilities and maintenance procedures.

Once delivery and installation are complete, *the supplier must provide all maintenance and service.* Through answering services and pocket pagers, suppliers and their professional staff are available 24 hours per day, 365 days per year to support patient and equipment care in the home, as repairs or replacement of equipment are needed. In cases where equipment cannot be serviced in the patient's home, temporary equipment must be provided at no extra cost. In some rural areas, suppliers routinely provide extra back-up equipment in case the primary equipment fails. This back-up equipment also is provided at no cost. This means two items actually are dedicated to one patient. However, the supplier only is reimbursed for the cost of providing one item. Billing and insurance-related paperwork during the time a patient needs HME may drive up administrative costs incurred by a supplier. For instance, it may be necessary to issue two bills each month: one to the insurer and one to the patient for his or her copayment. Finally, after an individual no longer needs HME, the retrieval process may be as complicated and costly as delivery. *The supplier must disassemble the equipment, carefully disinfect it and pay the cost of storage until it is rented again.*

III. Issues to Consider in Reform

Assessing the successes and failures under Medicare and Medicaid is an instructive starting point in charting the nation's health policy well into the 21st Century, whether these programs are retained in whole or in part, or abandoned in favor of something new. Medicare's authors envisioned in essence a "triage" system, with the hospital as the primary point of entry for most patients. For that expected group of individuals who might require further care incident to their hospitalization, the drafters created two very limited benefits: a restricted number of days of care in a skilled nursing facility; and a similarly restrictive home care package consisting of two separate components to be used either together or in the alternative: (a) skilled nursing and aide care provided by home health agencies; and (b) durable medical equipment provided by suppliers.

Implicit in this scenario is the assumption that the preponderance of patient needs are either acute or immediately incident to an acute episode. Thus, the program provides for the 70 year old stroke patient who requires immediate hospitalization followed by post-acute rehabilitation leading to complete or near-complete restoration. And in 1965, perhaps stroke victims, or individuals with fractured hips and the like indeed accounted for the preponderance of Medicare patients. But this concept of health care as synonymous with acuity is not in harmony with today's emerging cohort of patients whose needs are chronic and for whom the acute care model is clinically inappropriate and financially costly. In view of the services and technology now available in the home, the acute model is also unnecessary in all respects save one, but that one is too frequently determinative of where care today is rendered; payer policies biased against patients with chronic conditions and unrecognizing of home care as an alternative to (rather than incident to) hospitalization.

Thus, as the work on creating a national health insurance program progresses from conceptual to operational issues, the following preliminary views are presented on the interrelationship and policy implications of three broad trends or principles that are appropriate to the current debate with respect to home care and the HME services industry: (A) technology; (B) chronicity; and (C) home medical equipment.

A. Technology

Trend: Technological advances are making possible high levels of quality care in the home that, in prior years, was available only in institutions.

Home care generally was a relatively unexplored concept in 1965, and, as envisioned by Medicare's authors, the home (durable) medical equipment benefit consisted primarily of standard wheelchairs, walkers, commodes and hospital beds — items often used for post-acute convalescence. This was the current state of technology, and the drafters aptly termed it the "durable medical equipment" (DME) benefit.

But as patients' needs have evolved, so too has home care technology. While traditional post-acute capability remains in place and available, an increasing array of new home care services and equipment is available to post-acute and chronic patients who, in prior years, would have required hospitalization: apnea monitors for infants; insulin pumps for the long-term diabetic; oxygen therapy for chronic obstructive pulmonary disease; power mobility devices for injuries and degenerative diseases (e.g., spinal cord damage, muscular dystrophy, multiple sclerosis, amyotrophic lateral sclerosis); parenteral and enteral administration of nutrition; oxygen ventilator equipment for the ventilator-dependent child or adult; and intravenous administration of chemotherapy or antibiotics for AIDS and cancer patients, to name but a few. In view of this evolution, the medical equipment supplier industry has dropped the out-moded term "DME" in favor of the more accurate phrase "HME."

Home care providers and suppliers of all types have been affected by the "sicker and quicker" phenomenon under the DRG hospital payment program. This was expected and, while challenging, is consistent with Medicare's original notion that home care is always incident to a prior acute episode. Less known and more unexpected is the fact that HME suppliers confirm an increasing number of their Medicare patients present with chronic needs also requiring recently available home equipment technology. Nor is the chronicity/technology trend restricted to Medicare's elderly. For example, low income Medicaid-eligible mothers are more likely to produce premature infants prone to Sudden Infant Death Syndrome. In prior years they remained in hospital nurseries for purely observational purposes until they developed past the SIDS threshold. With home apnea monitors, these Medicaid infants can be discharged earlier with no loss in necessary observation.

In short, technology and services are available to serve traditional post-acute patients as well as the emerging population with chronic needs, and in so doing forestall or shorten hospitalization. But public and private payer policy is lagging. To give but two examples: Medicare has virtually no home benefit for infusion chemo- or antibiotic therapy and many Medicaid programs do not cover home apnea monitors. As a result, unnecessary institutionalizations are still the norm because of physician convenience and the fact that current programs will cover certain equipment and services provided in an institution, but not in the home setting. With the continuing devastating rise in the number of individuals with the HIV virus, it is unfortunate that more people cannot receive the care they require in the home, a setting certainly more compassionate and cost-effective. During the development stages of national health reform, policymakers must be encouraged by our industry to reflect on how these advances in technology should be factored into any future coverage and payment program.

B. Chronicity

Trend: A large and growing number of current Medicare and Medicaid eligible beneficiaries have chronic rather than acute health needs.

In America, health care needs traditionally have arisen and been treated as a series of acute interventions provided sporadically in a physician's office or an institution. But current data indicate that, increasingly, patients are experiencing needs which are more chronic than episodic. Improved nutrition, healthier life-styles, better and earlier medical attention and a host of other factors contribute to the fact that people are living longer and not succumbing to acute illnesses. In conquering many acute health problems, however, we are surviving longer, thereby experiencing a greater incidence of chronicity.

In an important "humanistic" sense, this is a success. However, if the trend continues — as seems likely — the policy implications for health care costs are considerable. As embodied in governmental and commercial third party payer programs, current American health reimbursement policy has a pronounced tilt toward episodic and costly acute institutional interventions. To cite but one example: Medicare is still premised largely on the original authors' notion that necessary care will in the first instance be provided in the hospital with only very restricted benefits for that presumed minority of individuals who might require a period of post-acute convalescence at home or in a nursing facility.

This is not to fault Medicare's original drafters. Their work 25 years ago rested on an accurate reading of admissions and clinical data and experience from the 1950's and early 1960's. But more recent data available suggest strongly that to be responsive to the population served, health policy for the future must address a greater incidence of chronicity. Accommodating this fact within available funding likely will require policymakers to reconsider the bias toward institutionalization inherent in current public and private programs. *Turning to home care as a more cost-effective alternative thus becomes logical from a financial standpoint and humane from a purely societal view.*

C. Home Medical Equipment

Trend: HME is harnessing the technology and chronicity trends to produce a cost-effective alternative to institutionalization for many patients, while continuing to serve traditional post-acute patients.

The fact is that, increasingly, HME is being called on as a safe and less costly means of caring for both post-acute and chronic patients in their homes. The challenge for physicians, patients and HME suppliers is to continue caring for patients in the context of antiquated public and private programs that were designed with virtually sole emphasis on acute care in institutions. And as the chronicity/technology trends continue through the 90's and into the next century, such programs will be increasingly "out of synch" with public policy fashioned 25 years ago or more at a time when patient needs were in the main acute in nature.

The tension is obvious and benefits no one. The opportunity for the future is to capitalize on the cost, clinical and social advantages of maintaining chronic and post-acute patients in their homes through neutralizing the present policy tilt toward acute institutional care. In this way, home care (including HME), is not disadvantaged when patients and their physicians select a care setting. NAMES respectfully suggests that the policy goals of Congress should be to make public and private payer policy setting neutral at the very least and, to the extent politically feasible, to create some incentives for home care. The result would be the maintenance of existing acute capability where appropriate, but an increased flexibility to serve both post-acute and the emerging chronic patient with technology and services in the less costly non-institutional environment.

At the conceptual level, accomplishing this goal is relatively easy, requiring only that policymakers adopt a limited number of guiding principles, as described in the following recommendations:

- *Retain and preserve both the current Medicare and Medicaid existing HME benefit;*
- *Facilitate patient access to HME services independent of institutionalization or an acute care episode, where appropriate ;*
- *Identify HME services as a required (rather than optional) benefit under any new health reform legislation;*
- *In the alternative, where home care and HME services are not included in the standard or minimum benefit plan, allow actuarially-equivalent home care and equipment to be substituted at no additional premium cost, under a standard or minimum benefit plan; and*
- *Expedite recognition of new technology available in the home.*

If policymakers are prepared to enunciate these broad policy principles or recommendations, the HME services industry would welcome the opportunity to provide input on ways to implement them. The HME services industry's current efforts to provide quality patient care through ethical business practices, certification and accreditation should secure firmly its place at the table during this most crucial debate of health care reform.

IV. Conclusion

Home medical equipment suppliers are faced with issues that already have begun to affect the services they provide. How well these issues are addressed — ensuring access to quality home care, eliminating unethical business practices and coordinating and supporting the continued development of home care services — will determine the extent to which home care becomes a vital and cost-effective contributor in America, thereby fulfilling its great promise to the future of health care.

Three factors drive the growth of health care expenditures: (1) demographics, (2) price, and (3) utilization of services. Any reformed health care system must assure that incentives are appropriate to reduce utilization. Conflict of interest must be eliminated and patients must have an incentive to not use health care services unless they are required — that is, health care reform must promote the responsible use of health care services by all parties, providers and recipients alike.

Finally, home care is an important component in the delivery of both acute and long-term health care. Any reformed health care system must contain reimbursement for appropriate health care services in the lowest cost alternative setting, including the home.

* * * * *

The National Association of Medical Equipment Suppliers (NAMES) is a nonprofit trade association comprised of over 2,100 HME suppliers in over 4,500 sites across the country. Based upon individual patient needs and according to physicians' prescriptions, NAMES members furnish a wide variety of equipment, supplies and services for home use. These items may range from traditional medical equipment such as walkers, oxygen and hospital beds, to highly sophisticated items and services such as parenteral and enteral supplies for complete nutritional support for individuals who cannot digest food normally; apnea monitors, which allow parents to closely monitor high risk infants' breathing; and specialized wheelchairs and other technologically-advanced equipment, which are custom-designed for the needs of rehabilitation patients. A substantial portion of HME patients/clients are Medicare and Medicaid beneficiaries.

Statement of Louis Núñez, President,
National Puerto Rican Coalition

House Ways and Means Committee
Subcommittee on Health
Hearings on Health Care Reform
February 9, 1993

Mr. Chairman, and members of the subcommittee, my name is Louis Núñez, and I am President of the National Puerto Rican Coalition. The National Puerto Rican Coalition is a membership association which represents over one hundred Puerto Rican community-based organizations as well as hundreds of concerned individuals. NPRC's goal is to further the social, economic, and political well-being of nearly six million American citizens of Puerto Rican descent throughout the United States and Puerto Rico. I wish to thank you for this opportunity to provide you with the National Puerto Rican Coalition's view of the health care problem for Puerto Ricans.

The Problem

The loss of manufacturing jobs in the Northeast coupled with astronomical health care costs directly correlate to the scarcity of private health insurance in the mainland Puerto Rican community. With a 35% increase in the U.S. Puerto Rican population during the last decade, the need for affordable health care is essential for the future of the Puerto Rican community.

Between 1983 and 1986, Puerto Rican persons under the age of 65 accounted for over 25% of Medicaid cases, compared to 18% of African-American persons and 3% of non-Hispanic Whites. A substantial number of Puerto Ricans tend to use the hospital emergency room for basic medical care. Only 62% of Puerto Rican mothers received prenatal care in the first trimester of pregnancy, compared to 82.7% of non-Hispanic Whites. These statistics illustrate that although Puerto Ricans are covered by Medicaid more than any other ethnic group, the condition of their health care has not improved, thus necessitating a change in health care policy; any reform in health care must focus on, and be sensitive to, the traditionally underserved populations such as the Puerto Rican community.

The Extent of the Puerto Rican Health Care Crisis

- ◆ Almost five percent of Puerto Ricans use the hospital emergency room for basic medical care, compared to .8% of Mexican-Americans and .2% of Cuban-Americans.
- ◆ During the period from 1985 to 1988, Puerto Rican persons between the ages of 45 and 64 used a physicians office only 4.8 visits per person compared to African-Americans (5.6 visits per person) and non-Hispanic Whites (6.5 visits per person).
- ◆ Puerto Ricans had the highest infant mortality rate of 12.3% between 1983 and 1985 which 3% greater than the rate of the general population.
- ◆ Puerto Rican mothers are almost twice as likely to give birth to underweight babies (9.4%) than non-Hispanic Whites (5.7%).
- ◆ Between 1983 and 1986, only 50% of Puerto Ricans had private health insurance compared to 81.5% of non-Hispanic Whites and 57.6% of African-Americans.
- ◆ Twenty-one percent of mainland Puerto Ricans (or .6 million people) were uninsured, compared to 12% of non-Hispanic Whites. The mainland Puerto Rican population is 2.7 million.

- ◆ Since 1987, Medicaid benefits for the island of Puerto Rico have been capped at \$79 million while the medically indigent population is approximately around 1.7 million, almost half of the island population.

Characteristics of the Puerto Rican Uninsured

NPRC contends that the major factors causing the lack of adequate health care coverage for Puerto Ricans have been structural rather than mere changes in behavior. Puerto Ricans, a large proportion of whom are unemployed, suffer from unacceptable levels of poverty. As a result, this group has not had access to decent and sufficient health care. To fully understand why Puerto Ricans are less likely to be insured, one must look at factors such as economic restructuring, unemployment, and poverty.

Economic Restructuring

The nine cities where the majority of US Puerto Ricans lived in 1980 lost almost one million manufacturing jobs between 1963 and 1982, representing a 44% loss of manufacturing employment. These losses were in the industries that typically employed Puerto Ricans: light industry in the northeast, and steel and related industry in the midwest. The greatest loss of these jobs, 30%, occurred in the decade after 1972.

The concentration of unemployment and poverty that resulted from these changes has hit Puerto Ricans especially hard. Of the fifteen cities with the highest rates of poverty in 1980, the four suffering the greatest deterioration since 1970 were all cities with large Puerto Rican populations, specifically, Newark, NJ; New York, NY; Chicago, IL; and Philadelphia, PA.

The relationship that these massive economic changes have had with the socio-economic deterioration of entire communities is undeniable. And it is clear that Puerto Rican families have been more vulnerable than other minorities to the forces that have caused their standard of living to plummet.

Unemployment & Poverty Figures

Although significant numbers of Puerto Ricans in the United States have entered the economic mainstream, the fact still remains that the current poverty rate of 40% among Puerto Ricans is nearly three times the national average. The unemployment rate for Puerto Ricans is also higher than that of any other Hispanic communities. This social phenomena deserves national attention and special concern. Concentrated in cities that have suffered a collapse in the industries that employed them; the breakdown of family and community links, as well as the ensuing isolation of individuals in increasingly smaller family units and the deterioration of their living environment; circulatory migration to and from the island of Puerto Rico, coupled with the parallel economic and social crisis there; and the lack of institutions to perform the binding role that the Churches performed in the African-American communities — all these factors have contributed to the deterioration of our social and economic network, and makes the Puerto Rican case specially troubling and deserving of attention.

Unarguably, the high levels of unemployment and poverty in the Puerto Rican community have had negative ramifications for this group in terms of health care coverage, among other things. Suffering are those Puerto Ricans who are unemployed and without private health insurance. And even individuals collecting Unemployment Insurance are not provided health benefits. Moreover, a large number of Puerto Ricans face barriers in purchasing health insurance due to poverty. The following facts illuminate the severity of the problem facing a large portion of the Puerto Rican population as they fight against high levels of unemployment, poverty, and low levels of health care coverage.

Puerto Rican female labor force participation in 1991 was 42%, compared to 51% for all Hispanics, and 57% for non-Hispanics. For men, the labor force participation rates were 66% for Puerto Ricans, 78% for all Hispanics, and 74% for non-Hispanics.

At 11.6%, the 1991 incidence of joblessness among Puerto Ricans was the highest of all Hispanic subgroups. Puerto Rican youth, 16 to 24 years of age, experienced a particularly high rate of unemployment, 20.2%. In addition, during 1990, the unemployment rate for Puerto Ricans rose by 2.3 percentage points.

In terms of poverty, Puerto Rican income figures are the lowest within the

Hispanic community. In 1990, the median money income for Puerto Ricans was \$16,200. The corresponding figure for Hispanic households was \$22,300, compared to \$30,500 for non-Hispanic households. Moreover, Puerto Rican children are the poorest in the nation. In 1991, the child poverty rate for Puerto Ricans was 57%, compared to 45% for African-Americans, 38% for Hispanics, 13% for non-Hispanic Whites, and 36% for Mexican-Americans. In 1991, Puerto Rican child poverty increased by one percentage point.

Finally, of all the Hispanic groups, Puerto Ricans had the highest rate of families living below the poverty line. In 1991, the rate for Puerto Rican families was 39.7%, an increase of 2.2 percentage points from the previous year. The corresponding rates for Hispanics, African-Americans, and non-Hispanic Whites were 26.5%, 30.4%, and 8.8%, respectively.

The high poverty rate among Puerto Rican families may be related, at least in part, to a high proportion of families maintained by females without a spouse present. In 1990, 64.4% of the Puerto Rican families maintained by a female without a spouse present lived in poverty.

Conclusion

With health care reform underway, we are bringing to your attention the plight of the Puerto Rican community, a group which has been underserved by the present health care system. Any legislation designed to address American health care needs must include the following:

- ◆ A fair Medicaid reimbursement policy. Most physicians have refused to care for Medicaid clients because of lower state reimbursement rates, thereby overburdening the emergency room capabilities of inner city hospitals.
- ◆ An expansion of federal support to include community-based organizations which have been able to provide the Puerto Rican community with information on immunization, preventive, and prenatal care. Studies in the mental health field have indicated that Puerto Rican use of facilities have increased when outreach campaigns have been conducted with the assistance of community-based organizations.
- ◆ Subsidies for Americans with low incomes or those who are unemployed so that they can have access to health insurance.
- ◆ Support for hospitals and clinics with staff who understand the distinctiveness of the Puerto Rican community and who are culturally sensitive to Puerto Rican issues, such as kinship and family.
- ◆ Increased spending on student aid programs to encourage Puerto Rican students to pursue studies in the medical field.
- ◆ Assistance to minority-owned small businesses who wish to band together to form larger health purchasing groups. Must also base employer insurance ratings on a community-based rather than an experience-based rating system.
- ◆ An increase in Medicaid benefits provided to residents of Puerto Rico. Although not ideal, a current proposal hike of \$25 million over 5 years should be enacted as soon as possible to help the island deal with the preventive health care crisis.

Mr. Chairman, members of the Committee, Puerto Ricans in the United States are law-abiding citizens who care about their families. Puerto Ricans are patriots and their children have been serving in the defense of our country for the better part of this century. Puerto Ricans, like all Americans, are pursuing the "American dream," but some things can not be achieved if the playing field is uneven.

To provide decent and sufficient health care coverage for all Puerto Ricans, quality investments must be made. The National Puerto Rican Coalition and the Puerto Rican community expect no more or no less from the federal government.

Once again thank you for the opportunity to submit a written statement. Any questions would be welcomed.

Please direct all questions to:

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**STATEMENT OF WILLIAM J. RAND, M.D.
DIRECTOR, THE RAND EYE INSTITUTE**

I have been interested and involved in the public policy debate regarding the American health care system for years. In 1989 I submitted testimony to the Subcommittee on Medicare and Long Term Care of the Senate Finance Committee. I have had discussions with the Senators and Congressmen who have the most expertise in health care matters, as well as with congressional aids and advisors specializing in health care.

I have discussed policy with health care experts within the previous administration. I was asked by the Bush administration to review the President's Comprehensive Health Reform Program and submit a detailed response. In doing so, I had the opportunity to see and review in detail, the information and statistics that are shaping the opinions of our leaders and experts in the health care debate.

I believe that I have a unique perspective of the health care system. I am the Director of the Rand Eye Institute, a center of professional excellence and one of the largest eye surgical centers in the country. I enjoy a reputation as a leading eye surgeon and as an innovator in my field.

I have participated in the development and improvement of some of today's most innovative technology for cataract surgery, including small incision sutureless cataract operations with instantaneous vision restoration. I am one of the most experienced eye surgeons in the country, with more than 15,000 major eye operations to my credit. The average eye surgeon may perform 700 to 1,000 such operations during an entire lifetime career. I am 46 years old and I look forward to a productive and challenging career in my profession.

From its inception 12 years ago, I have developed and guided the Rand Eye Institute, and the Rand Eye Foundation, a non profit clinical research and education division of the Rand Eye Institute.

I serve as a member of the Board of Directors of the Diabetes Research Institute Foundation, of the University of Miami School of Medicine. Because my 8 year old son has diabetes and requires four or five insulin injections daily since he was 18 months old, I have become very concerned about the level of technology and quality care that our future health care system will offer. I am concerned about the accessibility to health care and the availability of affordable health insurance that my son will encounter.

I have witnessed first hand, the destructive effects of misguided legislation that, despite good intentions, caused changes in the medicare system that have very negatively impacted upon the Rand Eye Institute and most other centers of professional excellence. Medicare fee reductions and the Resource Based Relative Value Scale recently enacted, saved the government less than \$300,000 in reimbursements related to Rand Eye Institute medicare billings, yet mandated new reductions on balance billing that cost the Rand Eye Institute nearly \$1.2 million in additional non government revenue. This has impaired our research and education programs, ended virtually all new equipment acquisition, and made it necessary seek all opportunities to redirect the Rand Eye Institute away from service to the elderly.

The leading eye surgeons in our country are, one by one, actively planning their withdrawal from the care of the elderly (medicare patients). They are actively engaged in developing skills to implement newly available technology to serve younger, non medicare patients who will want elective refractive surgery, in order to eliminate the need to wear eyeglasses. Within only a few years, it will become difficult to find any of the best eye surgeons willing to perform the vital service of cataract surgery because cataract surgery has been made ludicrously and artificially cheap, with reimbursement and maximum allowable charges less than 1975 levels. Eye surgeons have a more attractive alternative available to them, free of perceived government distortion and interference in their profession.

Reorienting myself away from care to the elderly is certainly an economic necessity for myself, one of the most experienced and active providers of sight restoring surgery for the elderly.

I care deeply about what kind of health care system we will leave to our children. Will there be freedom and incentives to create the next generation of great advances in medical technology or will misguided legislation remove the incentives to the extraordinary achievements that our health care system can provide in the future.

The same technology that expands our abilities, also crowds our desks with a flood of information. Senators and Congressmen can be called upon to vote on complex health care legislation that can be measured in units of thickness and pounds, with complex text and testimony that few could ever find time to study.

The reality of our political system is that it is often difficult or impossible to achieve a bipartisan consensus to enable passage of effective legislation. This is especially true when it comes to health care, where so many respected experts disagree with each other as to what to do. There are so many special considerations and special interest groups and political pressures. And again, the masses of printed information for legislators to consider.

The stakes are too high for health care reform to be a gamble or an experiment. This is true not just for the economy or for those who work in the health care field. Our children and our grandchildren will either be the beneficiaries of accelerated medical progress or the victims of lost opportunities for disease prevention and cure.

Realistic proposals for national compulsory health insurance must involve minimal expense to government, with reduced expenditures to business and industry from present levels. We must provide for affordable health insurance for everyone, with government assistance where necessary. Unnecessary government responsibilities and entitlements must be avoided. We must achieve a cost efficient health care system that provides true value for expenditures. Potential abuses must be curbed in the most effective ways. Time consuming and expensive government regulation must be kept to a minimum.

While we learn to provide affordable health care access to all, we must maintain what is good and unique in our present health care system and continue to provide incentives and opportunities that will attract our best people and set free the creativity of the individual. We must preserve the individual's right to upgrade his or her level of care and freedom of choice. It is essential that we preserve and maintain our existing centers of professional excellence and make it possible to continue to create new centers of professional excellence in the future.

We must create a system of compulsory national health insurance that we create specifically for the United States and it must be a uniquely American conception. We can learn from other countries, but we must keep in mind that none of them has yet made a success out of their health care systems. We must avoid the rationing of care and long lines and impersonal service that has always seems to accompany government imposed health care.

We must provide universal unrestricted access to competent medical care for all the citizens of our nation. It must be done with minimal expense to government to avoid unbalancing our already troubled economic system. It must allow for a reduction in the excessive health care expenditures presently borne by American business and industry, in order to make them more competitive in the world marketplace. Health care must become affordable, with affordable health care insurance for everyone. Government must provide appropriate levels of financial assistance whenever it is necessary but not when it is unnecessary.

A cost efficient health care system must evolve that returns true value for health related expenditures. System abuses by providers and patients must be controlled, but without losing the good will and mutual trust of the providers, and without excessive and expensive government intervention and regulation.

We must build upon what is good and unique in our present health care system. America has always prided itself as the land of opportunity. This must remain true for our health care system.

We must provide incentives to attract our best people into the system, and we must value and reward creative individuals.

Americans must be able to upgrade their care and be free to go out and seek the best doctor when they feel the need to do so. They should be able to obtain an additional level of care, in the form of more comprehensive care or convenience or level of service. The upgradability of care is a right we must protect, but it is not an entitlement to be paid for by government.

The American health care system must allow its finest medical centers to finance their continued growth and renewal, and encourage the development of new centers of professional excellence.

Building on The Strengths of The American Health Care System

The United States health care system has evolved into the world's most sophisticated and advanced system. This has been due to the freedom of the individual and to the incentives inherent in our free market economy.

Value in Health Care : The High Cost of Not Curing disease

In plain terms, you do not have to pay for treating patients with diseases that no longer exist. The future can be very bright in terms of eradicating those diseases that presently consume most of our health care budget.

We have a health care system that has, over the past 15 or 20 years, advanced medical technology from the relatively ineffective "age of clinical diagnosis," into the "age of therapeutic treatment."

We must have as a national goal, the preservation of this system of excellence, because it is leading us to the "age of disease eradication." The quiet revolution that is occurring in medical technology today, will soon give us the ability to really control disease outcomes. This ongoing revolution in medical technology is at the heart of our health care cost problem, and it also represents the ultimate solution to the high cost of disease.

The assertion is made that there is an unsustainable cost growth. Currently, health care expenditures are about 13% of the gross domestic product (GDP), up from less than 6% of GDP only three decades ago. But we receive far more health value for this 13% than we received for the 6% of the GDP, three decades ago.

There are people who are being kept alive today and people with dramatically improved quality of life who would not have been saved from death or ongoing affliction had they been subjected to the less expensive health care technology of the 1960's.

Because of inflation, almost everything costs three or four times more than it did three decades ago. To that we must now add the impact of new technology expenses that did not have to be paid for in 1965, because the equipment or procedure did not yet exist. A good analogy would be the technology improvements in today's automobiles which are more expensive because of they routinely include automatic transmissions, air conditioning, and air bags as standard equipment.

Health care can legitimately consume a higher percentage of the GDP if it indeed provides the citizens of our society with the means to live longer and healthier lives.

If the system is efficient, health care can consume even 16% of the GDP by the year 2000. It would be a bargain, if we receive equivalent value in benefits to society.

Some researchers have erroneously predicted that between 23 and 43 percent of the GDP will go to health care by the year 2030. This fails to take into consideration all the great medical advances that will come into existence during the intervening years. We have just recently entered the age of technology and that accounts for much of the sudden elevation in the cost of health care in this country.

Although there are billions of dollars being spent on newly perfected procedures, many of these procedures offer greater financial savings to society in the form of reduced dependency and increased productivity.

Our senior citizens are no longer "old" when they have perfect youthful vision restored after a few thousand dollars worth of cataract surgery. What is the true dollar savings to society when they can go out shopping in the mall rather than suffer progressive loss of sight, and end up in a nursing home as wards of the medicaid system. And how much does it cost for repeated visits to their eye doctors when surgery is delayed, especially considering that the inevitable surgery will make frequent visits unnecessary.

This more complex, intricate technology of cataract surgery, that enables the lives of millions of senior citizens to be enriched each year, adds up to a lot of health care dollars, but it really saves the whole society more than it costs. At first, health care researchers thought there was fraud and abuse because of the sudden increase in frequency and expenditure. After spending hundreds of millions of dollars to police and preapprove cataract surgery, the inspector general finally found out that there was less unnecessary cataract surgery than any other kind of surgery (1.7%), and even this percentage reflected only poor medical record documentation of the need for the surgery. In reality, almost no one would submit to eye surgery if he can see well.

Nevertheless, government has continued to punish cataract surgeons for their innovation. Government has injured the reputation of ophthalmology and ophthalmologists with incorrect allegations and sensationalist hearings. Government has reduced their fees in error, in spite of evidence that cataract surgeons perform one of the most vital ongoing humanitarian services in this country.

This is indicative of the consequences of misguided legislation. It must be reversed, and the next round of mistakes must be stopped. Health care reform is needed, but it must be smart.

It is not likely that health care will ever cost more than 16 to 20 percent of the GDP. Many of the diseases that we currently spend billions of dollars on, will soon be cured and cost virtually nothing.

The potential future breakthroughs in medical treatment will yield tremendous savings to the health care system, as well as to society in general. Imagine a world without cancer, Alzheimers disease or diabetes. The cost savings to society would justify any percent GDP expenditure. When these cures come to pass, the cost of the health care system will fall considerably.

At the turn of the century, tuberculosis was the leading cause of death. Imagine how much money we would be spending on all those people confined to beds and requiring intensive treatment if tuberculosis had not been almost eliminated. A report made in 1900 would have predicted a tremendous percentage of the health care dollar going to tuberculosis management. We do not have to pay for that because the disease was virtually cured.

Our health care dollars will be going towards new treatments that will rehabilitate people who today go untreated because the technology is not yet there. New efficiencies and cures for old diseases will curtail what we now perceive as an unsustainable cost growth.

Funding Research

The Federal investment in biomedical and applied behavior research has increased its proportion of GDP from .12% in 1970 to .16% in 1992. This is still grossly insufficient, since the greatest economies to our health care system will result from the cures that research can provide. If we feel we are spending too much on cancer treatment, then we must create the funding necessary to facilitate private initiatives to eradicate this costly disease. The federal government can offer matching grants to private foundations that fundraise capital from the private sector, for research projects deemed to be in the national interest. Projects can be certified by a board of reviewers. But if a non profit research foundation can raise significant funding from the general population, that may be presumptive evidence of the worthiness of the research endeavor.

I am a member of the board of directors of the Diabetes Research Institute, at the University of Miami, School of Medicine. We are currently engaged in a 60 million dollar building and research program that will result in the assembling of 19 teams of the finest endocrinology and genetics researchers in the world, dedicated to a "Manhattan Project," like intensive assault on diabetes. We expect that we will cure and eradicate diabetes before the end of this century. This is a private fundraising initiative, and it will save our country more than 50 billion dollars a year in health care expenditures and lost productivity.

Government needs to be involved intensely in medical research efforts.

The Problem and The Political Solution

13% of Americans are without health care insurance. But this means that 87% of Americans do have health care insurance.

Of the 33 million who are without health care insurance today, thirty percent of the uninsured have incomes below the poverty level and 32 percent have incomes between 100 and 200 percent of the poverty level. This represents a relatively small amount of assistance that is needed, considering the size of the system. Of the 33 million who are uninsured, only about 10 million people are below the poverty level and need full assistance. Only about 12 million people need partial assistance.

Although the problem involves millions of people, the system seems to serve most others well and we should avoid unraveling the entire fabric of the health care system, because it will not be easy to reweave the whole garment in the reality that is the political arena.

I believe that the best route to health care legislation that would be effective and efficient, and yet preserve our system of extraordinary excellence, would be for the leadership of both parties, to come together for the express purpose of creating a true non-partisan high level commission, with bipartisan support, charged with producing a workable plan that would satisfy both parties and most Americans.

It is only when health care reform ceases to be a political issue and only when consideration of all of the probable consequences of legislated action can take place in an impartial atmosphere, that coherent, effective legislation can come into effect.

There is no person in our country who will not sooner or later become sick and die. The real cost of misguided legislation in health care will not be measured in dollars. It will be measured in the statistical chance for survival that the future will offer to us and our children and our children's children.

OVERVIEW OF CBO SCORING FOR COST SAVINGS UNDER REFORM PROPOSALS

TUESDAY, FEBRUARY 2, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 15, 1993

PRESS RELEASE #2
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THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM: OVERVIEW OF CBO SCORING
FOR COST SAVINGS UNDER REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the guidelines for scoring Federal and private savings under health care reform proposals. The hearing will be held on Tuesday, February 2, 1993, beginning at 10:30 a.m., in room B-318 of the Rayburn House Office Building.

In announcing the hearing, Chairman Stark stated: "Many health care reform proposals rely on Federal savings to finance new coverage, or to provide subsidies to low-income individuals and to individuals who are now uninsured. The Congressional Budget Office (CBO) is the referee that determines how effective each cost-containment proposal may be in generating real Federal savings. It is critical that the Subcommittee understands the scoring rules that will apply to all of the many reform plans."

Dr. Robert Reischauer, Director of the Congressional Budget Office, will present CBO's current policies regarding the scoring of health care cost containment proposals. Dr. Reischauer will be the only witness at this hearing.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

In 1992, national health expenditures in the United States reached an estimated \$808 billion, according to projections by CBO. These expenditures are expected to increase by between 10.5 and 11 percent each year, reaching nearly \$1.7 trillion in the year 2000.

Public spending, primarily payments to providers under the Medicare and Medicaid programs, accounted for about 40 percent of total national health expenditures in 1992.

Federal Government payments accounted for approximately 29 percent of total health spending in 1992. This share is projected to increase to slightly more than one-third of all health spending by the year 2000.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, February 16, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

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FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will ~~not~~ be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

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Chairman STARK. Good morning. The Health Subcommittee of the Committee on Ways and Means will continue its work on health care policy with a hearing on costs and coverage issues.

These hearings will begin to lay the foundation for us to work with President Clinton to enact health care reform legislation.

Today, we will examine issues relating to the assumptions underlying estimates by the Congressional Budget Office of savings from health care cost containment proposals. Today's hearing follows a hearing that the subcommittee held last Congress on July 11, 1991. At that hearing, Dr. Reischauer, for the first time, I believe, described the rules that CBO would use to score legislative proposals to contain health care costs. This was an important presentation by CBO since, prior to that statement, there had been no real definition of health care cost containment.

One of the real difficulties of the deliberations of the Pepper Commission was that there was no real way to judge alternative proposals to cost controls. Once CBO joined the process, there was, and is, a standard basis of comparison.

Under the accepted rules of congressional scoring, CBO has been the umpire of debate on many issues. I thought that said "vampire," but it says "umpire." Throughout the 1980s, CBO scored hundreds, if not thousands, of provisions in annual reconciliation bills.

There has been considerable criticism of CBO, often from my colleagues, that CBO's rules have been too lenient. CBO has become, I can attest, a tough act. During the annual reconciliation debates, the only proposals that would definitively reduce Federal spending were scored as providing savings. CBO demanded clear and unequivocal evidence that a proposal would produce savings. Theoretical models and assumptions were not enough. This is as Senator Gramm and Senator Rudman wanted it. This is how it should be. The process is fair, as all proposals must meet the same, tough standards.

When we turn to the health care reform debate, the crucial question for any proposal again and again will be, "does it really reduce spending?" This is the key issue.

Under the pay-as-you-go rules enacted in 1990, projected Federal savings can be used to meet the costs of expanding health insurance coverage.

Workers and others in the private sector want assurances that their health insurance premiums, already too high at approximately \$5,000 a year, do not continue their upward spiral.

Every member of this subcommittee, including the Chair, has had their share of frustrations with CBO scoring. But the fact remains that CBO scores provisions based on a uniform set of rules that apply equally to all proposals, Republican, Democrat, liberal and conservative.

As we approach the health care debate, it is critical that we all understand the basic rules that will apply when scoring reform and cost containment proposals. If we ignore those rules, we should not be surprised to learn that our favorite strategy may be scored with no savings.

Today's statement by Dr. Reischauer, I hope, will assist all of us, all Members and others involved in the health care reform debate,

to structure their reform proposals in a manner that will receive favorable scoring by CBO.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. Thank you, once again, for these hearings and for Dr. Reischauer, CBO and the budget process.

Reform of our health care system is, obviously, one of the most daunting challenges facing President Clinton and, indeed, we the Members of the Congress. The complexities of estimating health care cost savings, which the Health Subcommittee will examine, supports this observation and I think illustrates fairly well why health reform is not going to be easily solved.

Mr. Chairman, that old saw, the "devil is in the details," is always relevant to legislation considered by the Ways and Means Committee. I believe we will learn today, however, that the "devil" in health reform may very well be in the estimates as well.

Press reports indicate our new President has already been frustrated by this devil. The Health Subcommittee will also find its work more difficult because of it.

When considering the "devil" today, I think it is important to stress that the "truth," as handed down by the budget estimators, is not necessarily fact. It is merely a best guess based on modeling and the scant research literature on cost containment strategies. This best guess only becomes "truth" for the purposes of scoring legislation.

So in my opinion, we cannot responsibly assume that this score-keeping "truth" will produce the kind of dollar savings you can take to the bank or spend. The only place you can deposit these savings is in the Federal and health expenditure baseline at the Congressional Budget Office.

This distinction between the CBO baseline and the real world is important, and to ignore it could easily lead us to bad legislation which may be fraught with more untoward and unpredicted outcomes than cost containment.

Mr. Chairman, I stress these points because we are about to hear that price controls will limit health care cost growth, while health market reform will not.

CBO draws this conclusion despite the dismal Federal record with price controls on health in our economy. The Nixon era efforts to slow costs through limiting prices had no substantial effect. And as prices have been constrained in Medicare, whatever savings have been garnered, in other words, for the Federal budget have been passed on to the private sector in cost shifting.

The Chinese menu approach to cost cutting applied to Medicare through the budget bills of the 1980s has only exacerbated overall health cost growth. And, as we have learned from this Medicare experience, providers will find ways to overcome limits on prices, even if based on a legislatively set global budget. Instead, again in my opinion, we need fundamental reform of the incentives in the health care system.

I can understand the reticence of the estimators to score significant savings for health market reform. Such restructuring is untried and is dependent on the response of consumers, providers, and health plans to new incentives. But many experts agree that

the best strategy to reduce the volume of medical services, as well as price, will come through new incentives for consumers, providers, and health plans, rather than governmentally imposed price controls.

Health care expenditures can only be effectively limited by attacking both sides of the cost equation, volume and price. The test of a cost containment strategy ought to be whether it will fundamentally shift the way medical care is practiced and financed. It would be a shame, Mr. Chairman, if the health reform process becomes seduced by budget numbers which look good on paper, but will not stand up under the pressures of the real world.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Let me be brief. You know, we have a habit in hearings to state our conclusions before we have heard the testimony. And I think, Mr. Thomas, if I might say so, I think that doesn't serve the process very well. We haven't even heard Dr. Reischauer's testimony.

Mr. THOMAS. Will the gentleman yield?

Mr. LEVIN. Yes. You have read it perhaps, but you know we need a dialog on health care, and not taking our preconceived notions and minimizing testimony before it has been unfolded.

Before we have heard one word from Dr. Reischauer, there is an effort to discredit what he is going to say, because it doesn't fit into a particular ideological framework.

I will just close by saying I think we need to approach this whole issue with a great deal of practicality and less of our preconceived notions of what will work and what won't work. What hasn't worked in health care issues and debate is a lot of rigid ideology, and so I am anxious to hear from Dr. Reischauer, and I don't think it is fair to essentially minimize his testimony before he has even opened the first page on it.

Mr. THOMAS. Will the gentleman yield very briefly?

Mr. LEVIN. Yes.

Mr. THOMAS. Perhaps the gentleman does not know that I have just come from three terms on the Budget Committee listening to Dr. Reischauer on not just health care, but virtually every other subject in the Federal budget, and I can assure you, I already know what is on the pages before he opens them, and I wanted to let him know that our relationship that we carried over from the Budget Committee will continue here. And that is, I am interested in the real world and not game playing, according to the budget.

I thank the gentleman for yielding.

Chairman STARK. If I could make one additional point, the Chair has been as frustrated, as any Member of the House, from time to time by budget rules. I have used the example that money spent on prenatal care, in the real world, would be assumed to save perhaps \$5 in outyears, whether those are 5 or 10 years out.

I think we on this committee and in the delivery community know that as surely as the sun comes up in the east. I have learned, however, that if I spend \$1 or try to spend \$1 on prenatal care, I am scored with raising the deficit \$1. But if I try to spend \$5 on prenatal care, I don't get scored.

Why? Because there is no law that requires me to spend the money, and that is the rule. Now, while that frustrates me, I be-

lieve that we can all learn to live with a set of rules; they may not always seem right at the appropriate time or issue. The fact is we have to have some set of rules. We like them when they work to our advantage, and we don't like them when they work against us.

But it would behoove all of us to know what they are. And I think we would all agree that they have been administered relatively evenhandedly. We win some, lose some.

Today the rules of the game will be described to us. We all can learn the game rules or get around them in our own inimitable fashion, which is what I am sure we will try to do during the course of the next year or so. But in the meantime, we would like to have the referee, in the guise of Robert Reischauer, outline the rules to us. We can begin to find out how they will work to help us or hurt us, depending on what the issue is that we seek.

If there are no other burning opening statements from the Members, I would like to recognize Dr. Reischauer, and ask him to expand on his testimony, paraphrase it, or add to it in any way that he is comfortable. At the end of that time we will go ahead and inquire in our normal fashion.

Welcome back, referee, and happy to hear what you have to say.

STATEMENT OF ROBERT D. REISCHAUER, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. REISCHAUER. Thank you, Mr. Chairman. I appreciate the opportunity to be here, even though I have been called the devil and a vampire before the hearings begin. It is nice to have a new set of faces on this committee, although, as Mr. Thomas said, I have had dealings with many of you in the past, and I hope to continue the friendly dialog that we have developed over the past few years.

With your permission, Mr. Chairman, I am going to submit my prepared statement for the record and use the next few minutes to summarize the way that the Congressional Budget Office (CBO) goes about estimating the potential effectiveness of the cost containment provisions that are included in many of the health reform initiatives that are being debated today.

Chairman STARK. Without objection, your testimony will appear in its entirety in the record, and anticipating that there may be questions that Members will ask that would require you to submit something subsequently in writing, I would ask that we would hold the record open for 5 additional days for you to submit anything that we can't cover today. So please proceed.

Mr. REISCHAUER. In a nutshell, CBO is careful, conservative, and cognizant of the tremendous uncertainty that surrounds all estimates of savings proposals. We rely heavily on the evidence generated by more than two decades of efforts to constrain health care costs, efforts that have not been a resounding success.

Let me summarize what we have learned from past cost control efforts. First, we have learned that there are a number of ways that costs can be controlled. These include increasing the share of costs paid out of pocket by consumers, which, by the way, has fallen fairly steadily during the postwar era; expanding controls on the use of services through effective managed care systems, such as fully integrated health maintenance organizations (HMOs); and in-

stituting price controls supplemented by monitoring of the volume of services. I agree with the exception noted by Mr. Thomas—that cost controls might be effective in one sector of the health care arena but that they often result in higher costs in another sector.

By and large, CBO's cost-estimating procedures have been directed toward Federal expenditures, not national health expenditures as a whole. For example, we estimate the savings that might be gained from such policies as reducing the tax subsidy given to an employer that provides health insurance, and imposing and enforcing caps on expenditures—although we do not have a great deal of experience with that kind of cost containment in this country.

Second, we have also learned from our experience that cost control mechanisms that are effective, restrain the freedom of consumers or providers in some way. Unfortunately, the more effective mechanisms for holding down costs are also the more intrusive ones.

A third lesson from our experience is that the whole is not equal to the sum of its parts. Cost control mechanisms that effectively hold down expenditures in only one segment of the health care system may not generate systemwide savings because of cost shifting and other behavioral responses of providers. This means that cost controls that are applied selectively to some groups of consumers or to some providers, but not to others, are much less effective than those that are applied to the health sector as a whole.

Unfortunately, most of what we know about constraining costs is derived from incremental changes in our health care system, from relatively modest changes in payment methods, coverage, or eligibility. One may legitimately question how applicable these findings are to the systemic changes in health care that are being proposed today. Of course, there is evidence from the experience of other countries whose health care systems are arranged in fundamentally different ways from that of the United States, but such findings must be used with extreme caution. The substantial cultural, political, and economic divisions that exist between the United States and other countries mean that the responses of citizens, providers, and insurers elsewhere may have only limited relevance to what would happen in the United States.

Systemic change or fundamental reform involves thousands of decisions, and from a cost estimator's perspective, the devil is in the detail. Regulations that would be issued long after the passage of any reform legislation could well determine whether a particular reform had a marginal or a significant impact on future health care expenditures. They could even determine whether savings would result or whether additional costs would be incurred.

Furthermore, systemic reform would take a long time to implement. We would need several years to build the institutional infrastructure that is called for under some of the proposals.

In addition, years might pass before all of the behavioral responses to a restructured system had played themselves out. As a result, the savings from a reformed system could grow or they could erode as the years went by.

In summary, estimates of the savings associated with major reforms will be highly uncertain and will have a fairly wide margin of error. Let me illustrate some of these difficulties by discussing

the managed competition approach, which attempts to restructure health care markets in ways that would create incentives for consumers, insurers, and providers to be more cost-conscious.

CBO has been reviewing the various proposals for managed competition to identify the features that would maximize savings in national health expenditures. In our judgment, the eight key elements are as follows: first, creating regional health insurance purchasing cooperatives, or HIPCs, that would oversee and operate the restructured insurance market and help consumers make better-informed choices; second, establishing limits on the tax-exempt amount of employment-based health benefits and a requirement that employers contribute no more than a fixed dollar amount toward their employees' health benefits; third, putting into place standardized benefits and copayment rules and prohibiting supplemental insurance that would cover out-of-pocket costs under the standard package; fourth, making available uniform, reliable data on costs, outcomes, and quality; fifth, providing universal insurance coverage, so that significant segments of the population are not operating outside of this system; sixth, requiring all insurers to offer open enrollment periods and to base premiums on community rating; seventh, establishing an accurate method to account for the differences among insurers in the health status of their enrollees; and, finally, reducing significantly the number of insurers and ensuring that these organizations offer substantial, nonoverlapping networks of affiliated providers. In other words, you cannot have the same providers operating under all of the insurance systems that are offered within a geographic area.

Depending on how decisions were made within each of these dimensions, a managed competition plan could reduce health care expenditures substantially, or it could have little impact. For example, the cap on tax deductibility could be set quite high, relative to current insurance premiums, thus inducing little change in consumer behavior; or it could be set quite low, so that many people would be encouraged to join low-cost, efficient HMOs.

Such a cap could be allowed to rise rapidly, or it could be constrained by tying it to the overall level of inflation. The standard benefit package could provide a Spartan level of coverage, or it could be very generous, and so on. These are just some of the types of decisions that would affect costs.

Let me conclude by reviewing with you CBO's preliminary assessment of the Managed Competition Act of 1992, H.R. 5936, which was introduced in the 102d Congress and is being considered again. Under this proposal, a national health board would define the standard health plan; establish standards for reporting prices, health outcomes, and measures of consumer satisfaction; and provide information to consumers on the quality of care.

Plans that met the board's standards would be defined as accountable health plans. Employers would be required to pay a 34 percent excise tax on any premiums they paid that exceeded the lowest price of the accountable plan in their geographic area. All individuals except those working for very large businesses would be required to purchase their health insurance through the health plan purchasing cooperative in their area, if they wanted to receive favorable tax treatment of the premiums.

The Medicaid program would be replaced with a new Federal program that would help purchase health insurance coverage through the HPPCs for low-income individuals and families in the area. The program would include some cost sharing that would be based on income.

CBO's preliminary assessment is that this proposal would have national health care expenditures initially rising above baseline levels for a few years and then returning to approximately the same level that they would have reached otherwise. This result stems largely from the assumption that the health board would select a comprehensive set of benefits for its accountable plans. Initially, expenditures would be driven up because more people would be covered by health insurance. But over time, this effect would be offset as some people shifted into group or staff model HMOs because of the differential in cost.

Unfortunately, even the general estimate that I have just provided depends heavily on the board's decisions concerning the minimum benefits in the accountable plan and the board's willingness to set the tax cap threshold below the level that any traditional indemnity plan might be able to meet. To imagine the complexity of the situation that might face these boards in the braver new world of managed competition, consider the dilemma that the HPPC might be in if consumer satisfaction regarding the lowest cost plan was very, very low, although the health outcomes for this plan were no different from higher cost alternatives.

I know that CBO's approach to estimating the potential savings for various major cost containment initiatives has been extremely frustrating to many of you, particularly to advocates of specific plans who are convinced that their chosen strategy would have a dramatic impact on health care expenditures. I hope this discussion has given you some appreciation for why we have been both slow and cautious in responding to your requests for cost estimates. CBO's charter was not to help sell pigs in pokes. In many cases, the information needed to prepare reliable cost estimates is simply not available.

It would be irresponsible of us to seriously undercut the viability of a particular plan or approach with a cost estimate that was based more on guesses than on experience, analysis, and considered judgment. Nor does CBO want to take you on the budgetary equivalent of a bungee jump, where one day we report a certain proposal could save billions and then a month later, when the details are more fully specified, we estimate that national health care costs would increase significantly under that proposal.

We stand ready to help this subcommittee in the very difficult deliberations that face it this year, and, as you said, Mr. Chairman, we will try and be explicit about the factors that go into our cost estimating decisions. We will discuss these matters with you and the staff as we work together toward some better form of health care in this country.

[The prepared statement follows:]

STATEMENT OF ROBERT D. REISCHAUER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee. My testimony today will cover the Congressional Budget Office's (CBO's) methods for examining the effects that cost containment provisions in health legislation would have on national health expenditures. These methods will be illustrated using two bills that were introduced in the last Congress.

THE EFFECTS OF COST CONTROL PROVISIONS ON HEALTH EXPENDITURES

Over the past two decades, both public and private payers have made concerted efforts to apply many cost control strategies to the current health care system. As a result, there is evidence of how at least some types of cost containment approaches affect health care spending.

To give you an understanding of CBO's estimating methods, let me describe several options for controlling health care costs and the issues that these options raise for cost estimating. Where possible, I will also indicate the magnitude of the potential reduction in national health expenditures that might be estimated for each proposal.

Increased Cost Sharing for Health Services

Strategies that would raise the out-of-pocket costs of health care for consumers are predicated on the assumption that consumers would become more cost-conscious if they paid more. In other words, they would be more likely to consider whether the value of an additional visit to the doctor was worth the extra cost or they would seek out providers who were more economical or charged less. In considering this strategy, however, it is worth noting that average cost sharing in this country is continuing to decline. Consumers paid 27 percent out-of-pocket for their health care in 1980, but only 22 percent in 1991.

Cost sharing for health services could be increased in a number of ways. One could mandate minimum cost-sharing requirements for private insurance, eliminate dual insurance coverage that offsets cost-sharing requirements of individual policies, or prohibit the use of flexible benefit accounts to pay deductible amounts and coinsurance requirements.

As an example, if mandated cost sharing had been set at a level that increased out-of-pocket costs for the population with private fee-for-service health insurance by 40 percent in 1990, then national health expenditures would have been about 1 percent to 3 percent lower. This effect would be relatively small because consumers are not particularly sensitive to changes in their out-of-pocket costs. The reason is, in part, that they lack knowledge about alternative treatments, their costs, and their efficacy and, therefore, they delegate decisionmaking to physicians and other providers.

Expanded Controls on the Use of Services

Managed care can reduce inappropriate or unnecessary health care. Overall, however, the evidence of its effectiveness in reducing costs--other than through fully integrated health maintenance organizations (HMOs) with their own delivery systems--suggests that substantial savings could not be achieved by extending it to more people. Some reduction could occur, however, if expanded controls on the use of services were concentrated on populations with above-average hospital use.

One legislative approach might be to provide federal financial incentives to expand enrollment in HMOs. Incentives, however, would not necessarily elicit the desired increase in voluntary enrollment in HMOs unless the incentives were very large. Further, because only some types of HMOs are effective at reducing use and expenditures, only a portion of any new enrollees would actually use fewer services. Finally, the federal costs of the financial incentives to expand enrollment in HMOs could be as high or higher than the savings.

Another legislative approach would be to require that all consumers receive care through managed care organizations. For example, if everyone were required to enroll in a staff or group model HMO--the only type of managed care that has to date been demonstrated to achieve substantial savings--CBO estimates that national health expenditures could decline by as much as 10 percent. This is not an insignificant amount of savings; in 1991, national health expenditures were \$752 billion, and a 10 percent drop would be \$75 billion. Since there is no evidence, however, that even effective HMOs have been successful at reducing the rate of growth of health spending, and health care has been increasing recently at a 10 percent to 12 percent annual rate, we would still face the problem of higher health care costs in every subsequent year after these savings occurred.

Price Controls

Price controls could be effective in reducing both the level and the rate of growth of spending, but their impact would be partially offset because providers would increase the volume of services (or change billing practices) to recover lost revenues. In addition, price controls applied to only one segment of the market would generally result in higher spending in other segments of the market.

For example, if the prices of physician services under the Medicare program were reduced 10 percent, CBO estimates that Medicare's spending for these services would drop 5 percent. This estimate reflects our assumption that physicians would offset about half of their potential revenue loss through increased Medicare volume. If providers attempted to keep their overall revenues constant, spending on physician services by the non-Medicare population could also rise. As a result, although Medicare's spending for physician services would decline 5 percent, that reduction might not significantly affect the level of national health spending.

Stringent price controls may also affect access to care in some segments of the market. Access to care by Medicaid beneficiaries, for instance, has been adversely affected by the much lower prices that providers are offered in some states for serving this population.

Alternatively, government regulation could set maximum prices for physician services that all payers would have to follow. In other words, insurers would not be allowed to pay more, and physicians would not be allowed to bill patients for amounts above the regulated prices. Under such an all-payer system, providers could increase volume to offset some, but probably not all, of their lost revenue. Administrative costs would decline somewhat, since providers would not have to maintain and monitor many separate price schedules and claim forms. In addition, the authority that determined prices would also control their rate of increase. If the legislation included rules that would limit the growth in prices to less than the projected rate, then price controls in an all-payer system could generate lower national health expenditures than would otherwise occur.

Price controls carried out through a single-payer system could also reduce reimbursements and sharply cut administrative costs for insurers and providers. In fact, the one-time drop in the cost of administration could have been around \$30 billion to \$35 billion in 1991, under the conservative assumption that only the administrative costs related to billing and processing of claims would be reduced, if a single-payer system had been fully in place that year. National health expenditures would, however, have fallen by this full amount only if prices paid to providers had been reduced to reflect the lower administrative costs that they would have incurred.

In both an all-payer and a single-payer system, legislation that included provisions for uniform monitoring of providers' patterns of care would have an even greater impact than price controls alone. Such monitoring could reduce the magnitude of the response in volume and would allow the rate-setting process to take any volume increase into account in determining the next year's reimbursement rates.

Limits on the Tax Exclusion for Employer-Paid Health Insurance Premiums

In 1993, federal income and payroll tax revenues will be about \$70 billion lower because health insurance received through employment and health care costs paid through flexible benefit accounts are not treated as taxable income. Limiting the tax exclusion for employer-paid health insurance coverage could reduce health spending by inducing employers and employees to change the provisions of their insurance policies. If the new policies incorporated higher cost sharing by consumers, for example, the number of services used would fall. Alternatively, consumers might join effective HMOs, with the same result.

One way to limit the exclusion would be to treat some tax-exempt employee health benefits as taxable income. In 1990, for example, employer contributions averaged about \$110 a month for individual coverage and \$270 for family coverage. If the tax exclusion had been capped at those levels, the implicit federal subsidy for health insurance would have been reduced by about \$10 billion in that calendar year. National health expenditures would also fall in response to the lower subsidy, but by less than the reduction in the subsidy.

If such limits were enacted, workers who currently have coverage above the limits would have two choices. They could continue their current coverage and pay federal income and payroll taxes on the excess coverage. Alternatively, they could negotiate with their employers to cut back some, or all, of the coverage above the limit in exchange for higher wages, thereby also raising their taxable incomes. (Most employers would probably be indifferent between continuing current health benefits or substituting higher wages for them because both are tax-deductible business expenses.)

Lower amounts of coverage could be accomplished in several ways that would also help to control health care costs. First, traditional insurance could be replaced with effective HMOs. Second, higher copayments could be used to lower the cost of coverage. Third, coverage for some benefits (for example, chiropractic and dental care) might be dropped or scaled back. Finally, insurers could reduce the level of their reimbursement to providers, although this possibility would either limit the insured consumers' choice of providers or increase their out-of-pocket costs.

Limits on Expenditures

Legislation that provided for prospective budgets for hospitals, expenditure targets for physicians, or caps on overall national health spending would involve major changes in the existing U.S. health care system, but it could substantially reduce the rate of increase in health spending. The legislation would, however, have to include specific details of the mechanisms for setting, monitoring, and enforcing the limits.

For example, suppose legislation was passed that established prospective budgets for hospitals, with specific formulas for setting and updating them. Assume also that there was no leeway to increase the budget for a hospital when overruns occurred. In such a case, the impact on national health spending would be the difference between total spending for hospital services under the budgets and projected spending without the legislation. Similarly, if legislation set caps on expenditures for various segments of the health care sector, specified the formulas to determine the annual rate of increase in the caps, provided for monitoring performance under the caps in a timely way, and put in place enforcement mechanisms that would either make it impossible to exceed the cap or would make it possible to fully recover excess spending after it occurred, then one could estimate the savings by comparing the caps with projected spending in their absence.

Based on our assessment of the evidence on the effectiveness of limits on expenditures as they have been applied in the United States and in other countries, CBO believes the likelihood of success increases with a single payment mechanism or clearinghouse, restrictions on the ability to purchase health care outside the regulated system, and global budgeting for hospitals and other institutions. In addition, a continuously adjusting payback mechanism for physicians, as has been used in Germany and in some Canadian provinces, and budgeting or rate setting that applies to all providers and services would be effective in enforcing the limits. A good data system with uniform reporting by all providers to allow quick feedback would also be an important component of an effective strategy for limiting expenditures.

CBO's approach to estimating the potential impact of limits on expenditures in legislative proposals is to examine the proposal with respect to both the stringency of the limits and the specified enforcement mechanisms. Based on our best judgment, we then assign a rating for effectiveness, with a fully effective limit receiving a 100 percent rating and a completely ineffective proposal receiving a rating of zero. The estimated savings for any expenditure limit would equal the difference between the projected costs without the limit and the expenditure limit, multiplied by the effectiveness rating.

To illustrate the effect on national health spending of a fully effective cap, assume that legislation had been put in place beginning in 1986 that included a cap constraining the increase in national health expenditures to the rate of population growth (1 percent a year) plus 2 percentage points above the rate of general inflation. If such a cap were fully enforced, we estimate that national health expenditures would have been only \$651 billion in 1991, or about 13 percent lower than the approximately \$752 billion that was actually spent that year.

If, however, limits on expenditures were applied selectively to some groups and not others, then providers could increase prices and the volume of services for other groups in order to maintain revenues, without incurring penalties for exceeding the limits for the covered population. Although the market segment subject to the limits would realize savings, national health expenditures might not fall much.

Managed Competition

Managed competition is the central feature of proposals to restructure the health care market in ways that would create incentives for consumers to be more cost-conscious in their insurance and health care decisions. Increased cost-consciousness by consumers would give insurers and providers, in turn, the incentives to become more cost-conscious and efficient.

Many different proposals have been put forth under the "managed competition" umbrella. Some proposals of this kind could reduce health care costs, and others would have little effect. CBO is currently preparing a paper on managed competition. It will identify features that would help maximize the savings in national health expenditures under that approach. These elements include:

- o The creation of regional organizations (for example, health insurance purchasing cooperatives, or HIPCs) that would oversee and operate the restructured insurance market and help consumers make better-informed choices;
- o Limitations on the tax-exempt amount of employee health benefits and a requirement that employers contribute no more than a fixed dollar amount toward their employees' health benefits;
- o Standardized benefits and copayment rules, with a prohibition on supplemental insurance that would cover out-of-pocket costs under the standard package;
- o The availability of uniform, reliable data on costs, outcomes, and quality;
- o Universal insurance coverage;
- o The requirement that all insurers offer open enrollment periods and base premiums on community rating;
- o An accurate method to adjust for differences among insurers in the health status of their enrollees; and
- o A significant reduction in the number of insurers and the creation of insuring organizations that would offer substantially nonoverlapping networks of affiliated providers.

In combination, these changes to the current system could result over time in a reduction in the rate of increase in national health spending. Omitting some of these elements from a proposal for managed competition would significantly lessen its potential effectiveness. Even if all these elements were included, however, it would be extremely difficult for CBO to estimate the magnitude and the timing of the effects on national health spending, because of the complexities of analyzing a dramatic restructuring of the markets for health insurance and health services.

Two aspects of these proposals do provide some indication of the direction CBO's cost estimates will take. First, we have consistently taken the position that savings could be achieved by moving people from fee-for-service medicine into group or staff model HMOs. Thus, estimated savings would depend on the extent that a particular proposal would shift people into these types of managed care organizations. In addition, most proposals for managed

competition would limit in some manner the tax-exempt amount of employee health benefits. Federal revenues would be increased to the extent that the limits are tightened. If employees then chose insurance with more limited benefits and higher cost sharing because there was less subsidy to health insurance, there could also be a further impact on national health expenditures.

Assessing the full effect of restructuring the entire health insurance market, however, is much more difficult. Little information from either the United States or abroad is available on the time that it would take for all the changes to occur or on the magnitude of the impacts of these changes once they were fully implemented and all behavioral responses had occurred. We are convinced, however, that even if a managed competition approach with all the critical elements described above were carried out, its effects would occur over an extended period of time. Significant savings in national health expenditures would probably not occur within the usual five-year time horizon of CBO cost estimates.

A PRELIMINARY ASSESSMENT OF THE COSTS OF TWO LEGISLATIVE PROPOSALS

Estimating the potential costs or savings of health reform proposals is one of the most difficult tasks CBO has attempted. First, health expenditures are currently about 14 percent of gross domestic product and are projected to rise to at least 18 percent by the year 2000. The effects of changes in this large a system must be uncertain. It is often difficult even to forecast spending in current federal health care programs, as CBO has found in recent years when Medicaid spending increased by 19 percent in 1990, 28 percent in 1991, and 29 percent in 1992, far exceeding projections. Moreover, many of the health reform proposals under consideration include provisions for which there is no actual experience and no solid evidence to be used as the basis for our estimates.

The task of estimating costs becomes even more complex since five years--the usual time frame for cost estimates--is not a long enough period for forecasting the impact of some health reform proposals. Some of them might require longer than five years to be fully carried out, and cost estimates that stop at five years would not provide the information that is needed to assess all their effects.

In addition, CBO is being asked not just to estimate the impact of these proposals on the federal government's budget, but also to examine their effect on national health expenditures and on the number of people with health insurance. National health reform involves important interactions between the private sector and the federal budget, but analyzing these interactions and their impacts is extremely difficult. As a result, estimating the costs and savings associated with health reform proposals requires more thought, more coordination and consultation with other federal offices such as the Joint Committee on Taxation, and more time than most cost estimates.

To illustrate the estimating issues and principles, CBO is providing a preliminary assessment of two health reform bills introduced in the 102nd Congress: H.R. 5936, the Managed Competition Act of 1992, and H.R. 5502, the Health Care Cost Containment Act of 1992. Although they are not current bills, the proposals represent different approaches to health reform and illustrate the complexity of making cost estimates in this area. CBO has not yet completed year-by-year estimates for the two bills, but it is possible to give you an outline of their probable effects on national health expenditures.

Our analysis reflects H.R. 5936 as introduced and H.R. 5502 as reported by this subcommittee. For both bills, we have delayed the implementation dates by one year to reflect possible enactment in late 1993. The Congressional Budget Office and the Joint Tax Committee have worked together in examining the effects of changes in the tax law.

The Managed Competition Act of 1992

H.R. 5936 would attempt to control costs and expand access to health insurance by restructuring the way health insurance is provided. The bill would establish a National Health Board to define a standard health plan; to establish standards for reporting prices, health outcomes, and measures of consumer satisfaction; and to provide information to consumers on the quality of care. Plans that met board standards would be defined as Accountable Health Plans (AHPs).

Changes in the tax code would encourage the use of AHPs, because employers paying more than the cost of the lowest priced AHP in the area would be required to pay a 34 percent excise tax on the costs above this amount. The self-employed would be allowed to deduct 100 percent of the costs of the lowest priced AHP. In each state, Health Plan Purchasing Cooperatives (HPPCs) would be established, and all individuals except those working for businesses with more than 1,000 employees (up to 10,000 employees at each state's option) would be required to purchase their health insurance through the HPPC to receive the favorable tax treatment. Individual contributions for health insurance could be deducted for tax purposes only up to the cost of the lowest priced AHP.

Finally, H.R. 5936 would replace the Medicaid program with a new federal program that would help purchase health insurance coverage through HPPCs for low-income individuals. Individuals and families with incomes below the poverty level would be eligible to join AHPs with no premium and only nominal copayments. Individuals and families with incomes between 100 percent and 200 percent of poverty would be responsible for paying a portion of premiums, based on a sliding scale.

CBO's preliminary assessment is that, after a few years, H.R. 5936 would leave national health expenditures at approximately the same level they would reach otherwise. Initially, however, national health expenditures would increase. This result stems in large measure from the assumption that the National Health Board would select a comprehensive set of benefits for its AHP. Because these benefits would be available to a larger group than is currently covered by health insurance, national health expenditures would be higher in the first few years.

The growth in per capita health expenditures would gradually slow, however. Because group model or staff model HMOs can provide health care more efficiently than other organizational forms, they would probably be the lowest priced bidders in many HPPC areas. Based on past performance, we expect their prices would be 10 percent to 15 percent below the price of similar fee-for-service plans, and the cost of enrolling in these HMOs would be fully tax-deductible. Thus, enrollment in them would probably rise more rapidly under managed competition than under current law, thereby slowing the growth in national health expenditures. After a number of years, these savings could offset the increased health care costs resulting from extending access to those who currently lack health insurance.

The Health Care Cost Containment Act of 1992

H.R. 5502, the Health Care Cost Containment Act of 1992, would attempt to control health costs by establishing limits on national health expenditures. Separate limits would be applied to Medicare spending and to national health expenditures. Limits would be enforced through rate setting, although states with approved programs and federally qualified HMOs would be exempt from the maximum rates. Access would be extended by expanding Medicaid coverage for pregnant women and children with family incomes below 200 percent of poverty and for all nonaged individuals with incomes below 100 percent of poverty. Medicaid payment rates would also be increased, and a new federal health insurance program for children would be started. Finally, Medicare would expand its coverage of certain prevention benefits and add a new prescription drug benefit.

CBO estimates that H.R. 5502 would reduce national health expenditures about 5 percent by the year 2000. Our preliminary assessment is that the Medicare expenditure limits would be 75 percent effective. We have a great deal of experience with rate setting and potential volume offsets in the Medicare program, which indicates that expenditure limits could be reasonably effective in controlling Medicare spending. At the same time, we are much less sanguine about the effectiveness of limits on other health spending. States would be permitted to operate their own systems as long as the growth in health care spending did not exceed what it would have been under the maximum rates. This calculation would be very difficult to make, and specific data on states would not exist in usable form for several years. Finally, the bill exempts federally qualified HMOs from rate setting. Federally qualified HMOs are more broadly defined than group or staff model HMOs and include organizational forms that have not been shown to be cost-effective. Because of these and other potential sources of leakage, we have assumed that the limits on expenditures for non-Medicare spending would be only 25 percent effective. It is our understanding that H.R. 200, the Health Care Containment Act of 1993, would limit the HMO exemption to group or staff model HMOs. While we have not completed an assessment of H.R. 200, we expect that its expenditure limits will be more effective than those in H.R. 5502.

The savings from the limits on Medicare and national health expenditures would be partially offset by provisions in H.R. 5502 that would expand insurance benefits and extend the population covered by health insurance. Overall, however, we estimate that H.R. 5502 would result in national health expenditures falling about 5 percent below the level they would otherwise reach by the turn of the century.

CONCLUSION

In the past, most health care legislation changed payment methods or levels in relatively small, discrete ways or expanded eligibility for existing programs. Thus, CBO has considerable experience estimating the impact on costs of such changes to Medicare and Medicaid. In general, reasonably good data and research studies permit us to develop well-founded estimates.

The task we are facing today, however, is a much more difficult one. Reform of the health care system is likely to involve massive changes in current health care financing and delivery systems and perhaps comprehensive restructuring of the markets for health insurance and health services. Estimates of the effects of such sweeping changes on overall health care spending, as well as on individual components such as federal health spending,

will be much less precise than estimates of changes in Medicare and Medicaid. For one thing, past experience does not encompass changes of this magnitude. Although there is some evidence from other countries, these findings must be used cautiously, because the substantial differences in cultures, politics, and economic systems mean that the responses of citizens, providers, and insurers in other nations may have only limited relevance to the United States.

In addition, it is likely that any health reform policy would require a number of years of development and would be phased in over a period of time. Moreover, it might take a few more years before it would be possible to discern the behavioral responses of all the participants in the health care and health insurance markets who would be affected. At the same time, of course, many other things will be changing, including overall economic conditions, the introduction of new technologies for diagnosis and treatment of illness, and--as our experience with AIDS and the recurrence of tuberculosis in recent years has shown--even the health status of the population. Thus, considerable uncertainty surrounds any estimates of the longer-term effects of health reform proposals on national health expenditures and on the federal budget. Nonetheless, estimates of the effects of different health reform approaches will provide useful comparative information on the relative costliness of, or the potential savings to be gained from, alternative proposals.

Chairman STARK. Thank you.

Last year, as you know, this subcommittee reported H.R. 5502 last August, and CBO staff estimated that we would save Federal costs of about \$94 billion in the year 2000, and total costs would have been reduced by about \$215 billion. Your statement, however, indicates that the revised guidelines for the 103d Congress set the reductions on H.R. 5502 at a somewhat lower level than you established last year.

Your statement also reports that the expenditure limits in H.R. 200 "will be more effective than those in H.R. 5502." Could you list for us the major changes in the scoring rules for 1993?

Mr. REISCHAUER. Basically, over the course of the past year, we have been talking to many experts in the health care area, and we have been examining the new literature as it comes out. From that work, we have developed a set of criteria by which we will judge proposals that have expenditure caps.

We have gone from a system in which we could provide you with an estimate based on the assumption that the cap would be 100 percent effective or zero percent effective, which is how we were operating a year ago, to one in which we look at various dimensions of the proposal and try to ascertain whether we think the cap will be, let us say, fully effective, 75 percent effective, or 50 percent effective.

Chairman STARK. In other words, you used to say it either works or it doesn't work. It was a yes or no?

Mr. REISCHAUER. We were explicit in telling you that that was our assumption; for example, if these caps are fully effective, these kinds of savings might result. But when a proposal is presented that would not reasonably be expected to be fully effective, I do not think that that is the proper way to go.

And so we have tried to refine our judgments, but at the same time let everybody know what factors go into them. With respect to something like expenditure limits, the question would be, are these fixed into law, or are they to be determined later by some more political process? In other words, will it take further legislation to change these caps? And is there a mechanism to enforce the expenditure limits that is likely to be successful?

Some proposals just set up expenditure limits, without specifying how those expenditure limits would be applied—whether at the subnational level, geographically, or at the level of individual providers. We think that certain enforcement mechanisms are more likely than others to be effective: for instance, if one had a clearinghouse or a single-payer mechanism; if there were restrictions on the ability to purchase health care outside of the established system; if there were global budgeting for hospitals and other large providers, particularly if there were prospective global budgeting; and if there were some form of continuously adjusting payback mechanism. Under the last provision, if expenditures begin to exceed the caps, discipline would be imposed with very little lag time. I mean, you can develop systems in which providers are, in a sense, punished for overspending that occurred 2 or 3 years ago, but those systems are likely to be less effective than a quarterly or semiannual system in which the reimbursement rates are ratchet-

ed down rather quickly if spending for a particular segment of health care is running too high.

There clearly would have to be comprehensive budgeting and rate setting and there would have to be a good deal more data and information provided to both the regulatory authorities and to the providers for such a system to work. And so what we at CBO do is to look at the various proposals and see how specific they are with respect to these dimensions. We then give them a judgmental ranking that indicates how effective we would expect the expenditure cap to be.

Chairman STARK. Do the revisions in H.R. 200 address the major revisions in the scoring guidelines, particularly with respect to recapture under State programs and exemption of staff in group model HMOs?

Mr. REISCHAUER. We are still examining that, and we expect to have an estimate on it by the end of the month or by the first week or so of next month. One of the serious reservations we had about last year's version of the bill was that these federally approved HMOs were, in a sense, outside of the system, and the definition of what would qualify under that provision was fairly loose. It would include some forms of HMOs or managed care that have not proved to be effective at reducing costs in the past.

In addition, last year's proposal allowed States to opt out of the national rate-setting mechanism if their total expenditures were likely to remain below where they would have been under the national system. If States do opt out, we basically have no way of knowing what their expenditures would have been. We do not collect much information that way.

One can imagine the difficulty you might get into with a State that right now has relatively low spending. The State would argue, "Well, left to our own devices, spending in our State would improve and get closer and closer to the national average. Otherwise, you are, in a sense, confining us to subaverage status." There was, we thought, substantial leeway in that mechanism for evading the caps.

Chairman STARK. One final comment. When do you suspect we will receive more specific guidelines and estimates for not only H.R. 200, but the other major cost containment provisions?

Mr. REISCHAUER. We are hoping to complete those by the end of March, when we will have analyses of three or four of the major alternatives that have been proposed.

Chairman STARK. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

To make sure everyone understands the context of my opening remarks, the question that I have asked you before and I will ask you now, based upon your admitted limitations, especially in an area like health care where you say on page 15 of your testimony: "Significant savings in national health expenditures would probably not occur within the usual 5-year time horizon of CBO cost estimates."

If we are dealing with a problem which as part of its solution is more and more emphasized on the preventive health care aspects, which don't kick in until years or decades later, why should we ask

you what your opinion is, given this kind of a limited structure? That is, I don't think you are capable of telling us it is a pig in a poke, so why should we ask you?

Mr. REISCHAUER. Unless we want to know——

Mr. THOMAS. And what the world is going to look like according to CBO for 5 years. Let me state it so you can answer it easily.

Is 5 years a reasonable time period to estimate the costs of a fundamental, comprehensive health reform package for all Americans?

Mr. REISCHAUER. No.

Mr. THOMAS. Thank you.

Mr. REISCHAUER. But we have been providing this subcommittee, and other committees and subcommittees of the Congress, with estimates of what our judgment would lead us to believe would be the impact of various proposals after they have been fully implemented and after we have had a chance to see the behavioral responses and institutional reforms that result. Now, you might say——

Mr. THOMAS. Fair enough. Let me ask you a specific question.

Mr. REISCHAUER [continuing]. That this is relatively speculative.

Mr. THOMAS. Let me ask you a specific question in regard to your estimates, pick up your line of argument.

In your testimony for H.R. 5936, on page 7, you make an assumption, which I think is fundamentally flawed, but you admit significantly shakes your decision on cost estimating under the limits that are imposed upon CBO. You say that initially, the national health expenditures, under that particular plan, would increase. "This result stems in large measure," I am quoting from you,

from the assumption that the National Health Board would select a comprehensive set of benefits for its AHP. Because these benefits would be available to a larger group than is currently covered by health insurance, national health expenditures would be higher in the first few years.

Mr. REISCHAUER. Yes.

Mr. THOMAS. What leads you to the assumption, within the structure of the National Health Board, the way the five members are selected, the requirement of partisan separation, the phase in over a period of years for the full 7-year term for all of those members, a requirement that the President make the appointment with an understanding of their knowledge of the health care system, would lead you to conclude that automatically the package that they would select would be comprehensive, greater than what is currently provided, and, in fact, a driver of costs initially?

What is there that led you to that assumption in that legislation and in the way in which the National Health Board is structured?

Mr. REISCHAUER. Well, first of all, I think we quite clearly stated that that was an assumption. You could certainly come back to us and say, imagine a package that is like this—much, much less comprehensive—and we could do another estimate under that set of circumstances.

Mr. THOMAS. You are asking—tell me why you came up with that conclusion, given the evidence that you had to go on within your model.

Mr. REISCHAUER. The evidence derives from what we have seen at the State level and elsewhere. Their systems show a continued

proliferation of mandated benefits, which have led to rather elaborate forms of health care. These trends have caused many large corporations to self-insure to get out from under that burden.

Mr. THOMAS. Would you concede that if it was a National Health Board that was constructed, under broad language passed by the Congress, supported by the President, that a State model probably is not a good example to follow in terms of an understanding of a need to respond to the problem?

Mr. REISCHAUER. We have a very difficult time in this country saying that certain procedures, certain treatments that are efficacious—that do improve health status—should not be covered. You know, I have a hard time seeing how a group of knowledgeable individuals, possibly doctors who have had a lot of experience in a health care system that basically has had no brakes on it for all of this century and who have been trained to provide every form of care that might increase the health prospects of their patients, are going to say, “Well, we are going to ratchet this thing down substantially below the current average for our society.” One has to remember—

Mr. THOMAS. I am driven by the clock, so I have to let me control the time and not you. We have been through this before. You do a great job of using up my time.

The point is this: all of those arguments that you have made were also made on the question of closing military bases, and Congress was never successful in closing one. And we set up a new structure which was comprehensive, which made an up or down decision, and which is now successful in closing bases. I don’t know why that analogy isn’t a better one to examine a National Health Board than your State model.

Second, is the way we are supposed to play the game then is to say to you that if Congress dictated a model to the initial National Health Board, which was a specific set of requirements, which was clearly a cost savings, and that the National Board could not increase that mix in any given year greater than the inflation rate, that you would then feel very comfortable about making an estimation which would show, one, that it saves costs, and that, two, in your world of 5 years, which no one believes is a reasonable time period on health care, that, in fact, you have a controlling model, because you are using some kind of an inflated factor to control the expansion of it. That then fits your model, which would show significant savings, correct?

Mr. REISCHAUER. If this package was specified in law—

Mr. THOMAS. And if the Board was not allowed to increase that package beyond a given inflated factor for a given year.

Mr. REISCHAUER. That would have more of an impact, yes. I do not live in a 5-year world because I like to live in a 5-year world. The Budget Act requires CBO to live in a 5-year world, and I do not want to carry that burden around during this entire hearing.

Mr. THOMAS. And that is why part of the devil is in the understanding of asking you for answers and letting you govern the process. It isn’t, I think, a very useful model for us in this particular arena.

I think you have been invaluable in other arenas where the 2 to 3 to 5-year timeframe makes sense, and in that context my opening

statement was and continues to be, I appreciate you telling me whether it is a pig or not, but I am going to look myself.

And if this Congress let's you define what we do on health care in a 5-year window on the budget game playing that you have to follow because of the act, we will have abdicated our responsibility to the American people, in my opinion, of setting up a system that in the real world will provide all Americans with affordable health care.

Thank you, Doctor.

Mr. REISCHAUER. Let me just say a word about pigs in pokes. It is not that a pig is an undesirable commodity. The notion is that—

Mr. GRANDY. Thank you for weighing in on that, Dr. Reischauer. I was about to say something myself. The gentleman and I have had disputes on pokes in the past, but I am glad you weighed in on my side. Thank you.

Mr. REISCHAUER. The issue is that you are buying something the size and quantity of which are unknown.

Mr. THOMAS. Sometimes when you try to tell us what is in the poke because of the 5-year limit, you are a mile away trying to identify what is in that poke, and my argument is you can't do it in a 5-year window.

Mr. REISCHAUER. And that is why we have been providing you with fully implemented estimates and not—

Mr. THOMAS. You are not going to get the last word, I can assure you. A 5-year window does not let you identify some pigs, period.

Chairman STARK. Mr. Levin.

Mr. REISCHAUER. Correct.

Mr. LEVIN. I hated to interrupt that. You know, before I ask you a question, I find it interesting that there is an effort to minimize the importance of action the first 5 years, and I just want to say that it is my guess that in the State of the Union Message, the President may focus on the long-term, but asking that we take actions that have some impact the first 5 years as well as thereafter.

On page 7, Mr. Thomas, in trying to escape the impact of your statement about the managed competition proposal, said that you were assuming selection of a comprehensive set of benefits. The implication was that it was something beyond the norm today, and I think you corrected that assumption.

When you say here your assumption is the Board would select a comprehensive set of benefits, your definition of that is something at the current average level of benefits?

Mr. REISCHAUER. At about that level.

Mr. THOMAS. Take that to the bank.

Mr. LEVIN. No, but I think that—

Mr. REISCHAUER. We are talking about a Cadillac plan here. That is the point.

For example, certain aspects of these bills suggest that we should extend prescription drug coverage in Medicare. Yet many private insurance policies now do not cover prescription drugs.

Mr. THOMAS. Is that in H.R. 5936?

Mr. REISCHAUER. No, no. What I am saying is that there are expansions in all of these programs that I think would lead to the creation of what is an acceptable minimal package.

Mr. LEVIN. So let it be clear, what this testimony does is to highlight: the proposals to change the tax system would have implications for consumers where they were desirous of a program beyond the current average of health care coverage, and I don't think you can escape that. And I think it is a realistic to assume that the Board would not go below the average, which means for lots of consumers there would be a reduction in terms of their benefit.

It is interesting how the debate has hardly started before one ideological approach and off we go from there. I think it is more important for us to try to find out what might work, what might not work, and some get decent estimates about the impact of particular approaches.

Now let me ask you in that respect, Dr. Reischauer, about your handling of H.R. 5502. You come out with a conclusion of a reduction in national health expenditures above 5 percent by the year 2000. That assumption is based upon a 75 percent effectiveness for Medicare expenditure limits, but only 25 percent in what is essentially the private sector.

Now, assume that the figure of 25 percent were 50 percent. Do you know what that would mean for the cost-effectiveness or the cost savings the first 6 or 7 years?

Do you have any idea what each 25 percent means?

Mr. REISCHAUER. We do not have that at our fingertips, but we will be glad to look at that for you and provide you with an estimate of it.

[The information follows:]

Each increase of 25 percentage points in the effectiveness rating would reduce national health expenditures by an additional 2 percentage points by the year 2000 under the health spending limits established in H.R. 5502.

Mr. LEVIN. OK. I wish you would, because I would also like you to tell us a little more about your—

Mr. REISCHAUER. The changes you refer to would probably have a marginal impact during the first six of those years. Mr. Thomas' point is exactly on-target here.

These changes, which are as radical as those in H.R. 5502, would take many years to implement. If you recall, in that bill you ratchet down the caps over time, and so, in a sense, the savings grow over time. Fifty percent effectiveness for a very small reduction is not going to produce very much in savings. And in the first few years, that is all—

Mr. LEVIN. The table, though, does show that in the year 1997, the savings would be \$23 billion; in 1998, \$35 billion in Medicare and other Federal expenditures..

Mr. REISCHAUER. That was a table that was done, I believe, last summer for the committee staff. It was based on a different methodology.

Mr. LEVIN. All right. Well, could you give us the—

Mr. REISCHAUER. We will be developing similar kinds of information for you using our new procedures.

Mr. LEVIN. OK. If you could also analyze the 25 percent to 50 percent.

One last question. What is your estimate as to the impact of administrative simplification under any system? Do you have a figure for that if we had a uniform set of forms, of procedures?

Mr. REISCHAUER. No. Do you mean in a single-payer system?

Mr. LEVIN. No, not a single-payer system.

Mr. REISCHAUER. I was going to say, I am setting up certain assumptions. You might get anywhere from between 30 to 50 billion dollars' worth of savings. So when you begin relaxing those two assumptions that I just gave—

Mr. LEVIN. Of a single payer, and what is the other one?

Mr. REISCHAUER. A single payer, uniform set of benefits, no-balance billing—you know, so that we have really simplified things—and electronic billing. You may get as much as 30 to 50 billion dollars' worth of savings. Then as you begin relaxing those rather restrictive elements, the administrative savings decline.

Mr. LEVIN. OK. Thank you.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Recognizing that it is very difficult to project these costs, especially since we have not embarked upon any particular major health care changes, we know for a fact that many States have been involved in this for some years. Have you, or is it possible for CBO to look at some of the State experience and possibly, if savings are realized there, compare that up on a national level to indicate to us what might be working in the field?

Mr. REISCHAUER. We have reviewed that evidence and actually have provided summaries of it to this subcommittee. There is some evidence that on the hospital front, some mild effectiveness was found for what basically were price controls in a few States, most of which have been abandoned during the past few years—

Mr. KLECZKA. Basically you are talking about—

Mr. REISCHAUER [continuing]. In part because the States could maximize their Medicare reimbursement by abandoning these limits.

Mr. KLECZKA. So you are basically talking about the certificate-of-need laws that were existing for a while, and for the most part are gone, and some other cost controls.

Mr. REISCHAUER. It is really the all-payer rate schemes that operated in New York, Massachusetts, and New Jersey, I believe, for various periods of time. What I am really saying is that we do not have a long history of successful State interventions along this line.

Mr. KLECZKA. Turning to your estimate, I believe, of last year on the single-payer system versus that of the General Accounting Office, I believe you folks were within a range of \$25 to \$30 billion in savings, and a more friendly figure came out of GAO to the tune of about \$70 billion.

Have you looked at that and analyzed what the major disparities were?

Mr. REISCHAUER. We are preparing a new paper that will discuss those differences.

Mr. KLECZKA. And when might that be available?

Mr. REISCHAUER. Excuse me.

Mr. KLECZKA. My colleague Jim wants to see that immediately. When might that be available?

Mr. REISCHAUER. In a month or so.

Mr. KLECZKA. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman, and welcome, Dr. Reischauer. I am very pleased to share your rethinking. I think it is very healthy.

As you know, my frustration has been your ability and the ability of others to give hard numbers to proposals that involve global budgets and soft numbers to proposals that involve managed care, and I understand why that is. But it is clear evidence that our estimating technology, so to speak, of today doesn't serve us, because it can't take into account behavioral changes.

You will recall, and my colleagues should know that I asked CBO to do an estimate of the impact of managed care, the savings that could be produced in managed care, just assuming that the experience of the large number of companies who have gone in this direction would be the same, were that experience applied to the rest of the population. So I was making the kind of superficial assumptions that have driven estimating to this point, and the outcome was really marvelous.

You know, \$64 billion in 1990, \$78 billion in 1992. And that assumption—I mean that kind of estimating I would say is as valid, and particularly from your discussion here, as anything we have done, because it at least looks at experience out there in the real world and applies that experience elsewhere.

And I guess the fundamental reason I find this so frustrating is that in manufacturing we have seen by process reforms, which is what managed care is, a change in the way you deliver the product, and in other sectors of our economy, not just manufacturing, but now in insurance and in banking and so on and so forth, as we reform the process, we have seen 20 and 30 percent savings year after year, and they don't stop through continuous improvement the way our DRG savings did stop, the way our price setting savings have stopped, and so on and so forth.

I don't want to use all my time in making that point, but it is why I welcome your rethinking. And I want to apply your rethinking to the concept of global budgets. Because if you look at global budgets set at the State level, there are several things that spring to mind. For instance, are you making the assumption when you estimate a global budget proposal that the global budget would be trying to provide the standard health care benefit, the same plan assumption that you are applying elsewhere? Because if you take that assumption, you cannot get away from the political pressure that will arise to break the global budget.

So I think your approach is far more valid than in the past. It is more complex, but it is more honest and more realistic.

But you really have to make assumptions about the plan that would be delivered through the State expenditure cap at the State level in that model as well as in any other model, because from that assumption flows the possibility of whether the limits will, in fact, hold. We know in Medicare, we have been unable to cut Medicare any significant percentage, any single year recently. And that demonstrates that it would be very hard for this committee to keep

Medicare to a cost of living increase, if that was the global proposal.

And so experience doesn't document that you can hold a global cut. Experience does document that process reforms can cut 20 percent a year in segment after segment of our economy. So I would like to hear you talk a little bit about two things in regard to global budgets.

First of all, do your estimates of global budgets take into account such problems as the higher health expenditures in some States versus others, the different types of illnesses common in some areas? What would happen if there was a big demand under global budget? And how does your budget deal with, for instance, a raging epidemic of AIDS in the cities and where would that money come from? And what are your assumptions in regard to that, and therefore, your assumptions in regard to the enforceability of the cap.

Because the enforceability is going to depend on taking money from rurals to support AIDS in Chicago, Los Angeles, and New York, good luck. So I want to know, how has this thinking changed your approach to global budget estimating.

Mr. REISCHAUER. Well, you are much further down in the global budgeting trenches than we are. What we are asking is whether a mechanism exists for enforcing a global budget? Giving the States a cap is, in a sense, one step more precise than a national cap, but it is still a long way from the provider's door. And in terms of global budgets for hospitals of the sort that are used in Canada—from which, in effect, there is little escape—those kinds of limits produce a number of incentives that we might not want. Those incentives are clear in the behavior of hospitals in Canada.

Mrs. JOHNSON. For example, you see, when you make the comparison to Canada, Canada is controlling growth and costs. Our global budgets would first impose a really staggering reduction in cost growth. I mean going from a normal—a high cost growth to a very normal very low cost growth.

Mr. REISCHAUER. This reduction would be phased in over a number of years, and as we phased it in, certain things would happen, if it were effective. One is the——

Mrs. JOHNSON. I guess what I am trying to get at——

Mr. REISCHAUER [continuing]. Technology—we might slow it down. Another thing is that the excess capacity we have in the hospital sector might disappear as institutions closed.

Mrs. JOHNSON. Well, all I am saying is that the assumptions that you have to make about the political impact of scaling down versus controlling scaling up are different. So that Canada's ability to controlling scaling up is different than our ability to ratchet down and then control scaling up.

And if you are talking about enforcement, I can see what you are saying when we are looking at the enforceability of the State caps and stuff, but part of enforceability is whether the plan that is going to be offered is going to be accepted. I mean that is the measure to which you are holding the Cooper kind of approach.

Mr. REISCHAUER. The more we leave decisions to, in a sense, future political forces, the less effective a global cap would be; that is what we are trying to point out. The more automatic the system

that is put in place—the less leeway there is to rethink these things—the more effective the system might be.

Mrs. JOHNSON. Yes. And so I really think it might be very, very helpful to us at this point. Because this is where your thinking is and this is where our thinking needs to be, is that if every estimate came to us with the kind of variables you describe, so that you say if the basic benefit plan were minimal, then this is the impact on cost. If it is what is currently standard, because we have to get a better grasp of which definitions are really going to matter, and one of the problems with the estimating to this point is that global budgets have been simplistically looked at as providing enforceability and so on and so forth, and so they get one estimate.

I don't fault anyone for that. I mean this is new—we are trying to deal with 14 percent of the economy. But I do think it would be very helpful to us if instead of giving an estimate, you gave some of the variables that in the end are going to drive the estimate, and maybe even some of the regulatory issues, because we have to understand whether we would be willing to deal with those issues, and therefore articulate the costs.

Thank you, Mr. Chairman.

Mr. REISCHAUER. As the chairman pointed out with respect to H.R. 5500, we are saying this: the caps in the non-Medicare sector would only be one-quarter effective. We are not making an assumption that these things work well.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Dr. Reischauer, I appreciate your testimony. As badly as I want to see expanded access in health care and have high quality care for all Americans, I know that unless we get control over costs, we are not going to have health care reform. And if history is any lesson then the incentives that we offer for voluntary action alone will not bring down the escalating growth rate of health care expenditures in this country.

We have to do more to make sure that we actually accomplish health care savings. In regard to the point that Mr. Thomas made about a national board trying to determine what type of benefits will be offered, yes, there will be a lot of pressure on that board to deny the types of mandated services that are now required by the State, such as mental health benefits, or mammography testing, or drug abuse treatment, but I am not sure that is the way we want to control costs in this country on health care.

We need to deal with why the fees for health care services are so high, and the volume of service is so high. I hope that we will learn from your testimony today that we must have some enforceable mechanism to make sure that the rate of growth of health costs will be controlled.

I want to follow up on the point that Mr. Levin made. Most of the health care reform bills want to bring about administrative simplification, want to bring about utilization review simplification, and want to simplify the burdens on health care providers. Many of us want to see tort reform in order to bring about the reduction in unnecessary medical tests; we would like to see a priority on primary health care physicians in order to have a more effi-

cient health care system; more preventive health care, as the Chairman alluded to in his opening comments.

If I understand your testimony, if we take our current system and do those types of reforms, that will clearly root out some of the inefficiencies in the spending of health care dollars today. A large part of those savings will be eaten up by increased volume or increased fees if we don't do anything other than those types of reforms.

Am I reading your statement correctly, that although it would bring about savings, some of those savings will be lost because of behavioral changes within the medical field itself?

Mr. REISCHAUER. I think that is certainly true, but a more important point is that we can do things that will affect the level of spending in this country—lower the level of spending—but that does not really affect the rate of growth of spending. And the real problem here is the rate of growth.

If we were to produce some kind of miraculous administrative reform that would save \$50 billion, solve the malpractice abuses that are in the system, and make other such changes, you might get 60 or 70 billion dollars' worth of savings.

And so rather than it being February of 1993 in our health care system, it would be March of 1992—and health care costs would still be rising at 10, 11, or 12 percent a year. We would have done nothing to fundamentally change the pace at which spending is going up. And I think that it is not necessarily true that we have a mass of greedy providers who are—

Mr. CARDIN. I understand that.

Mr. REISCHAUER [continuing]. Getting richer and richer. We have a very sophisticated form of health care delivered in this country, which is available on demand to Americans. It is a very good system for those of us who have it—but it is very costly, and we cannot afford the growth in expenditures over the long run.

Mr. CARDIN. If we take, though, those types of changes that will make our system more cost effective, eliminate some of the waste of money and bureaucratic nightmare that the current system has combined with some form of hard, enforceable global budgeting, wouldn't we then achieve the type of savings that we have talked about and provide the incentives for a more cost-effective system?

Mr. REISCHAUER. In one sense, yes, but in another real sense, no. To have expenditure caps that will lower spending, we are going to have to give up something, and that something might be the amenities that are found in American hospitals and not in Japanese, German, and British hospitals. It might be the access we have to care at the drop of a hat, or it might be the ability we have to choose among a wide array of providers and not be restricted to one path.

These features are all desirable aspects of the American health care system. But some of them, I think, are unaffordable in the long run, and we as a society are going to have to decide which ones we give up to control this spending.

Mr. CARDIN. You mentioned the all-payer rate system. Maryland, of course, still has the all-payer rate system, which, I would point out, has been very effective in keeping the overall growth rate of hospital costs in Maryland below the national average, saving the

Federal Government in its Medicare budget and saving State expenditures.

I notice that in your written statement you mention the fact that an all-payer rate system can be an effective way to help keep down the rate of growth of health care costs.

Mr. REISCHAUER. It can lower the level of spending; I do not think we know whether it can lower the rate of growth of spending. To believe that it is going to lower the rate of growth, you have to believe that administrative inefficiency is widespread and growing more and more extensive each year. That might be true, but I do not think that there are studies to show that it is.

Mr. CARDIN. But it clearly would stop the cost shifting to make up for some of the loss of revenues from one payer group to another.

Mr. REISCHAUER. Yes, and there is certainly a great deal of cost shifting going on.

Mr. LEVIN. Thank you. Mr. McDermott.

Mr. McDERMOTT. Thank you.

Dr. Reischauer, to support your answers to Mr. Thomas, I would suggest that required reading for this committee ought to be the "Politics of Medicare" by Dr. Marmer. If you want to look at how Medicaid came into existence, that book suggests that you don't necessarily get what you think you are going to get.

As I listen to you, one of the issues that—we have gone around and around on this global budget. But to me a global budget is made up of the price of a unit of service times the number of services delivered. That is basically how you derive a global budget.

I can't see any other way to control costs, except by a global budget. If you just control price, if you compete simply on price, you don't control cost, and if you control by limiting the number of services, you are not going to totally control it because the price goes up.

So can you give me any other way to control costs without a strictly enforced global budget?

Mr. REISCHAUER. At one extreme is the central control of overall costs. At the other extreme is the way we control costs and expenditures in most of the rest of our economy, which is by the consumer being faced with having to pay for whatever he purchases. We do not want to do that in health, though, because it would limit the access of low-income people to necessary routine medical care and the access of virtually everybody else to high-tech medical care.

But some of these proposals—for example, the one Mr. Thomas has been talking about—would attempt to provide stronger signals to the consumer in the form of reduced tax breaks. If the consumer wanted a more substantial plan or more coverage than the cheaper accountable plan, he or she would have to pay higher taxes for it. That is another way to restrain the rate at which overall spending is rising and, indirectly, the rate at which technology develops.

Mr. McDERMOTT. So the theory is?

Mr. REISCHAUER. If you think about something like the hi-fi market, companies there are also developing new technology all the time. So they come out with digital tapes—or high-definition television—and the machines cost \$2,000 or \$3,000. The consumer

decides, I do not want that; I will stick with my compact disc player.

We do not have a similar mechanism in the medical care area. Someone comes up with a new machine and says, this is infinitesimally better than the last one, but it costs four times as much. The judgment is made that it improves health outcomes a little, and we decide to buy it.

There is no mechanism for limiting the system, and we have to decide as a society how to put the brakes on it. You know, in a sense, we have had a Model-T and we have been pouring resources into the development of its engine, but we have not touched its brakes. We have to devote some resources to improving the brakes.

Mr. McDERMOTT. So at least one element in this is defining who makes the decision?

Mr. REISCHAUER. Yes. At the lowest level, it could be the consumer; at the highest level, it could be the national cap czar. In between, it could be an HPPC in a local—

Mr. McDERMOTT. Or the health care professions could also make that decision.

Mr. REISCHAUER. Or the health care professions.

Mr. McDERMOTT. So you have to make a decision someplace who is going to put the brakes on.

Mr. REISCHAUER. We have tried saying, "Well, certainly the corporations would do this. They are buying health insurance for most Americans, so why do not they put the brakes on?" Basically, though, they are relatively indifferent to how they provide total compensation to their employees—whether it comes in the form of cash wages or fringe benefits.

What they care about is total compensation, and so what we have seen in the past decade or so is these fringe benefits eating up what otherwise would have been increases in cash wages.

Mr. McDERMOTT. The theory of those people do not want a hard global budget is that by increasing the tax burden on the individual, the individual consumer will then make different choices and drive down the costs. They will opt for a plan that doesn't replace their knee or replace their hip, because they will say well, I am not going to have that; I will just live with the pain.

Mr. REISCHAUER. I think there is an expectation that this will occur at two different levels. First, it will exist at the level of the consumer or purchasing group—for example, the factory—and second, the health plan purchasing cooperative will exercise some kind of restraint. A third level, the national board—if it operates as Mr. Thomas suggests—will say, "Yes, there are some effective high-cost procedures, but this is a basic plan, this is what we are going to provide to all Americans, and we cannot provide the medical equivalent of caviar in everybody's diet."

Mr. McDERMOTT. So the board—

Mr. REISCHAUER. So there are three areas of restraint, and I think it is a mixed strategy.

Mr. McDERMOTT. The board is the one that is going to set the tone, though. If they set a high benefit package, then it is all on the consumer to make the decision, do I want to buy that whole package or not?

Mr. REISCHAUER. No, not really, because then the consumer—let us say that the benefit package established by the national board is an extremely generous one.

Mr. McDERMOTT. The auto workers, let's say.

Mr. REISCHAUER. The local HPPC would then approve for tax deductibility the lowest cost plan that has that coverage, and there would be no penalty—no tax penalty—for anybody who has that plan. So the deductible amount would be sufficiently modest for the signal to be transmitted to the consumer.

Mr. McDERMOTT. Could I ask one single question? Short answer. Do you see any evidence that CON was successful at all in controlling costs? Certificate of need.

Mr. REISCHAUER. I hesitate to give you this answer, because you are then going to ask me something else. The evidence seems to be, from our perspective, that, if anything, it increased costs.

Mr. McDERMOTT. Thank you. I will let that stand right there.

Mr. REISCHAUER. And I will elaborate that for the record.

Mr. McDERMOTT. I would appreciate it.

[The information follows:]

CBO RESPONSE

Health planning and certificate-of-need (CON) laws are approaches that have been used to influence or regulate capital investment within the health care industry. They serve to constrain capital outlays and thus subsequent recurrent outlays. Proponents of these approaches argue that health care facilities compete on the basis of quality rather than price and that this kind of competition can lead to duplicative, overequipped, or unduly lavish facilities. Proponents therefore contend that, in the absence of regulation, total investment in health care facilities would exceed what is optimal.

Opponents of these strategies argue that constraining inputs of one factor of production—capital—could cause increases in the use of other factors and result in an inefficient allocation of resources. Furthermore, capital regulation could reduce competition and increase prices by creating an additional barrier to entry into the health care industry and by hindering the expansion or restructuring of existing facilities and their services.

Federal participation in health planning evolved between 1946 and 1980 from a policy of encouraging voluntary efforts to develop health facilities to one of planning for a broad range of health resources, including the use of controls on investments by health facilities. During the 1970s, two statutory changes contributed to that evolution. First, Section 1122 of the Social Security Amendments of 1972 authorized the Secretary of Health and Human Services to enter into voluntary agreements with states to review proposed capital expenditures for hospitals. Hospitals that proceeded with disallowed projects could be denied reimbursement for interest and depreciation under federal programs. Second, the National Health Planning and Resources Development Act of 1974 (as amended in 1979) required in part that all states eventually enact CON legislation. Under such laws, health facilities, as a condition of licensure, would have to obtain prior approval from state planning agencies for construction and certain other projects. By 1979, about 90 percent of new construction, 25 percent of equipment purchases, and 60 percent of expenditures for modernizing buildings were subject to CON review. During the Reagan Administration, however, federal financial support for health planning decreased, federal CON requirements as a condition of states' receiving funds were dropped, and Section 1122 agreements were terminated.

Numerous studies have estimated the effects of CON and Section 1122 programs, although the scope of virtually all of this research has been limited to the effects of capital regulation on hospitals. CBO reviewed such studies in 1982; it concluded that there was no evidence that, on average, CON review had limited the growth in either unit costs, use of services, total investment, or the number of beds in the hospital sector.¹ The evidence did not preclude the possibility, however, that CON

¹ See Congressional Budget Office, "Health Planning: Issues for Reauthorization" (March 1982).

review programs in particular states or localities had achieved their intended effect. Thus, the same CBO study also reported evidence that CON review and other regulatory programs, when considered jointly, had restrained the use of computed tomography (CT) technology in states with relatively stringent programs.

Results of most subsequent research have been consistent with the 1982 study's basic conclusion that CON review had not reduced costs.² Indeed, one recent study found that CON review programs significantly increased a state's per capita costs for health care services overall, as well as for hospital services and nonhospital health services.³ This study adopted estimation procedures that allowed statistically for the possibility of two-way causation—recognizing not only that CON review and rate-setting programs might affect hospital costs but also that states with high health care costs might be more likely to adopt such programs.

Although the evidence seems clear that health planning and CON laws, as implemented in the 1970s, were generally ineffective in containing health care costs, those who support these approaches suggest that the experience of the 1970s and early 1980s did not reflect the full potential of health planning and CON programs as strategies for cost containment. They argue that the CON approach was applied in most states through an erratic and politically motivated process that resulted in decisions about capital proposals that were not consistent with cost-conscious expansion of health facilities and orderly adoption of new technologies. Proponents of the CON strategy suggest, for example, that it has been much more effective in reducing growth in the costs of health care in the few states in which CON programs have been linked to hospital ratesetting and to statewide (rather than local-area) health planning.

Moreover, it is possible that different approaches to the regulation of capital investments—for example, approaches that link the regulatory process more closely to other systems for controlling health care costs—might influence the level and pattern of such investments more effectively. The governments of many other countries control the capital acquisitions of hospitals, and these restrictions have led to lower rates of diffusion of medical equipment compared with the United States.⁴ A comparison of the availability of six technologies in the United States, Canada, and the former West Germany, based on data for 1987 and 1989, shows much greater capacity in the United States. For example, the United States had 3.3 open-heart surgical units per million persons compared with 0.7 in the former West Germany and 1.2 in Canada. Similarly, the United States had 3.7 magnetic resonance imagers (MRIs) per million persons compared with 0.9 in the former West Germany and 0.5 in Canada.⁵

However, in the absence of empirical evidence from the United States that restructured mechanisms for regulating capital investments in health care could reduce health expenditures, considerable caution would be appropriate in evaluating the cost containment potential of any proposal that depended on such mechanisms.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Dr. Reischauer, welcome to my new committee. I have enjoyed listening to your testimony on the Budget Committee for the last several years, and I am surprised today that we have just on the Budget Committee so many great subjects to talk about: pigs, brakes, economists, all good subjects.

² See, for example, S.R. Eastaugh, "The Effectiveness of Community-Based Hospital Planning: Some Recent Evidence," *Applied Economics*, vol. 14, no. 5, October 1982, pp. 475-490; Daniel Sherman, "The Effect of State Certificate-of-Need Laws On Hospital Costs: An Economic Policy Analysis" (Washington, D.C.: Bureau of Economics, Federal Trade Commission, January 1988); and Frank A. Sloan, Michael A. Morrisey, and Joseph Valvona, "Effects of the Medicare Prospective Payment System on Hospital Cost Containment: An Early Appraisal," *The Milbank Quarterly*, vol. 66, no. 2 (1988), pp. 191-220.

³ See Joyce A. Lanning, Michael A. Morrisey, and Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-hospital Expenditures," *Journal of Regulatory Economics*, vol. 3 (1991), pp. 137-154.

⁴ See Congressional Budget Office, "Rising Health Care Costs: Causes, Implications, and Strategies" (April 1991).

⁵ See Dale A. Rublee, "Medical Technology in Canada, Germany, and the United States," *Health Affairs*, vol. 8 (Fall 1989), pp. 178-181.

The brakes analogy bothers me a little bit. A lot of people in the audience here are probably too young to remember standard transmissions before synchromesh, but perhaps you do, and you recall that another way to brake a car was to downshift, and before synchromesh, if you downshifted too far you would strip the clutch facing and the whole car stopped.

And that is what concerns me about global budgeting, is applying the brakes too fast and the whole car stops and you don't have much left. So when you talk about global budgeting, as the top-down system of controlling cost that we haven't really talked much about in terms of the effect that it has on the automobile or the corpus of health care, and certainly we haven't talked about the effect that that top-down budgeting would have on quality of health care, although you have alluded to it a couple of times with statements about perhaps scaling back services, scaling back procedures that are available and those types of things.

But certainly any responsible legislator, before he goes in and reforms the health care system, would want to consider those elements of quality as well as costs, and I understand your job is just to tell us the scoring aspects. So you are not here to talk about that. But I just wanted to mention that.

An economist—I think you were in the Budget Committee when I told the story about the physicist and the chemist and the economist who fell down in the well and each had a theory as to how to get out—

Mr. REISCHAUER. We assume the ladder.

Mr. McCRERY. Yes.

Mr. REISCHAUER. But the other two guys are still down in the well.

Mr. McCRERY. Yes. So is the economist. He just thinks he is getting out. His state of mind is great.

The point is that economists make a lot of assumptions to derive their conclusions, and I was just wondering if it bothers you at all that a number of health care economists, economists who specialize in health care, have come to a different conclusion from that of your staff as far as the possible effects on costs of a managed competition arrangement, for example.

Mr. REISCHAUER. I tried to point out in my testimony that under certain circumstances, managed competition could save substantial amounts of money. I do not regard myself as the enemy of managed competition. Managed competition has a conflict built into it: competition on the one hand and management on the other hand. It is the interplay between the two that is going to produce savings.

Many people would like to assume, or to expect, large savings from plans that they label managed competition but that have very little in the way of management built into them. We are skeptical about that. In my testimony, I listed the key elements that would be important in determining whether or not a managed competition system produced substantial savings in resources. The savings would also depend on what level of basic plan was adopted and on the penalties for buying a plan that is more generous than the basic one.

Mr. McCRERY. And your estimates may be exactly right. In fact, the estimate that you ascribe to Mike Andrews and Jim Cooper's

bill is that it will in effect go on a "no savings," that overall health expenditures in the economy will be about the same as they are now.

Mr. REISCHAUER. But remember that we are estimating that somewhere between 15 and 20 million more Americans would be covered by health insurance and would be receiving more health services as a result of that coverage. You cannot get something for nothing.

Mr. McCRERY. Right. Per capita expenditures will go down. I mean you say that in your testimony. But you don't give it—

Mr. REISCHAUER. Expenditures per insured person might go down. But more people would be insured.

Mr. McCRERY. Yes. You say that that is good, it brings down the per capita expenditure, but in terms of overall health care savings you don't give it much credit. In fact, you don't give it the credit that you do 5502—

Mr. REISCHAUER. But, in a sense, what we are doing is getting more services for more money.

Mr. McCRERY. I understand.

Mr. REISCHAUER. Why aren't you going to tell me that we can get something more for less?

Mr. McCRERY. There are health care economists, though, and this is the point that I want you to agree with me on, that consider a managed competition arrangement to have more savings than you and your staff would give it.

Mr. REISCHAUER. Yes, I know, that is true. And there are an equal number on the other side who are saying that we are being overly generous to managed competition.

We at CBO are trying to do the best job we can in advising you; we have no ax to grind in any of this. We have brought in individuals who are expert in this area, both those who oppose and those who espouse managed competition, and no consensus comes out of their discussions and critiques. One group says that we are being too harsh in our set of assumptions; another says that we are being too lenient.

Mr. McCRERY. Mr. Chairman, I don't mean to denigrate the efforts of the CBO, I think they do a good job.

Mr. REISCHAUER. I am not taking it that way.

Mr. McCRERY. I think they do a good job, but I just want to point out that unfortunately we are constrained to take the estimates of the CBO, but I wanted to let everybody know that there are estimates out there that are far different from very respected health care economists, and I think as we reach the final conclusion of this debate on health care reform, we ought to consider those estimates as well as CBO's.

Chairman STARK. Mr. Andrews.

Mr. ANDREWS. Well, I think my friend from Louisiana makes some very good points here. It is important to understand that there are goals other than just cost savings involved in this debate that should be driving this debate, and you have recognized that. I mean we are here to talk about cost savings, but in truth, half the poor in this country are not covered by any health care today. We don't get to those people.

And one of the goals of managed competition and other proposals is to enlarge the umbrella of people that are out there. And one of the things I am most proud of with this managed competition bill is we do reach out and bring more people into the umbrella of health care.

In that regard, relative to Mr. Stark's bill, the Chairman's bill, and the managed competition bill of Mr. Cooper and Stenholm and myself and others, how many—can you estimate for us how many people get covered by each bill? I mean is there a percentage there of people that are covered and not covered?

Mr. REISCHAUER. I think our estimate is that the managed competition bill that you are referring to, H.R. 5936, would give 15 to 20 million more Americans health insurance coverage; H.R. 5502 would give 10 to 15 million more people coverage. So we are talking about substantial increases in both of these bills but by no means universal coverage.

Mr. ANDREWS. Now, in terms of what Mr. McCrery was asking you about, assessing costs and estimating costs, some of the proposals in the managed competition legislation are really so new it is very hard, is it not, to try to quantify what costs would be. Small businesses join together in what we call HPPC to negotiate for lower insurance costs. I mean is there any way to know what kind—really what kind of savings are going to be derived from that?

Mr. REISCHAUER. There is a lot of judgment involved in this, no question about it. What we are really talking about is changing the institutional framework in which health decisions are made and providing the actors with a set of different incentives. We are talking—with respect to the managed competition model—about a structure that does not exist anywhere in the world, and it would be wrong for me to say, I know what is going to happen, I know how this is going to play out.

Mr. ANDREWS. For instance—

Mr. REISCHAUER. We would change the political environment in which health care operates, and that would make a difference.

Mr. ANDREWS. For instance, let me mention another, and that is this outcomes analysis which is a very central part of any kind of managed competition approach. I mean it is amazing that we know more about the Buffalo Bills and the Dallas Cowboys than we do about our own doctors and our own health care providers. We know more about how good or how bad they are, about our professional athletes than we do about our health care providers.

Now, surely a stronger outcome analysis, more information is going to go right at the heart of the cost problem, will it not?

Mr. REISCHAUER. It will, and we are moving in that direction anyway under the system that we have right now. For example, Medicare is publishing information on outcomes and hospitals, and there is a rather large research effort under way at the Health Care Financing Administration and elsewhere on outcomes. So I think improvements are being made already. Shortly, the requirements—

Mr. ANDREWS. I may be misunderstanding your response. Improvements are being made in our health care system or improvements in our—

Mr. REISCHAUER. In our knowledge about——

Mr. ANDREWS. Or in your ability to quantify the savings?

Mr. REISCHAUER. No. In our knowledge about the outcomes generated by both different providers and different treatments. Now, as you say, we know very little about these, but just in the past 5 years or so, Federal Government resources have been directed at this lack of knowledge, and we should see improvements. The important aspect of the managed competition proposal, of course, is that the HPPC is responsible for gathering this information and disseminating it to the consumer so that the consumer can make a more informed choice.

So there is actually an institutional mechanism by which this information is made effective and has an impact on decisions.

Mr. ANDREWS. OK. Thank you very much, Dr. Reischauer.

Mr. Chairman, I have some questions that I would like to submit for the record.

Chairman STARK. We are going to keep the record open for a week to allow Dr. Reischauer to respond to any written inquiries, and without objection, the gentleman would be encouraged to do that.

Mr. ANDREWS. Thank you.

[Questions and answers follow:]

QUESTIONS SUBMITTED BY MR. ANDREWS

Question 1. You indicated in your testimony that the Managed Competition Act, H.R. 5936, would not change the national health expenditures (NHEs) by the end of the century, according to your best estimate. You also indicate that the price control approach, H.R. 5502, would reduce NHEs by 5 percent. Yet during the questioning you indicated that managed competition would expand coverage to the uninsured more than price controls. Could you be more precise about how many of the uninsured would be covered under the two plans?

Mr. Reischauer: Our estimates show that from 15 million to 20 million additional people would be insured under H.R. 5936. Similar estimates for H.R. 5502 show an increase in the number of insured people of from 9 million to 14 million.

Question 2. You assumed that the Managed Competition Act would have a comprehensive set of benefits. How do these benefits compare with the average set of benefits under the Health Care Containment Act for the year 1999?

Mr. Reischauer: The Health Care Containment Act does not specify any particular insurance plan. Rather, the insured population would be covered by a number of different plans, as it is today. We believe that the Approved Health Plan discussed in the Managed Competition Act would be somewhat more comprehensive than the average current plan; for example, it would cover certain preventive services and be more comprehensive in its coverage of prescription drugs and other services.

Question 3. Since your testimony does not permit a fair comparison of the two proposals, would you indicate by how much NHEs would fall under the price control bill if it covered the same number of the uninsured with the same benefits as the managed competition bill? Please indicate a specific number to the best of your ability.

Mr. Reischauer: I believe our estimates provide a reasonable comparison between the likely effects of H.R. 5936 and H.R. 5502. If insurance coverage under H.R. 5502 was extended to more people and was more comprehensive, there would be additional pressures on the global expenditure caps, and national health spending would be higher than estimated. We would require more detail on the exact proposal in order to provide an estimate of the magnitude of the increase.

Question 4. What caused you to revise drastically downward the effect of the price control approach in H.R. 5502 on national health expenditures—from about 12 percent, which was your preliminary estimate last year, to 5 percent for the year 1999?

Mr. Reischauer: We have done a great deal of research on the effectiveness of global expenditure limits since last summer. We have consulted a number of experts and have read a number of published studies on the effectiveness of various control mechanisms in the health area. We have examined both the limited experience with

global budgeting within certain geographic areas of the United States and have looked at the experience of other industrialized countries. We believe that our current estimates are better informed and more likely to be accurate, compared with the preliminary estimates we provided last summer.

Question 5. In predicting savings from H.R. 5502, have you applied a factor for the possibility that Congress would adjust the caps upward in the face of market place disruptions like hospital closings? In other words, is there any difference in your analysis between an expenditure cap that could be changed by an act of Congress and one that was set constitutionally perhaps?

Mr. Reischauer: Our estimates do not assume that the Congress makes an adjustment in the caps. If an adjustment were made, its effects would be shown at the time of the modifying legislation. In that sense, we would not show a difference between an expenditure cap that could be changed by an act of the Congress and one that was set constitutionally.

Question 6. Have you analyzed the potential for hospital closings, for queuing for health care services, and for increased fraud and abuse by providers under a price control approach? If not, would you perform such an analysis? I am interested in an analysis of how price controls versus managed competition would accomplish the goal of reducing spending.

Mr. Reischauer: As you have noted in your comments, any health care reform that constrained costs would be likely to entail some reduction in the number of providers, and this reduction in turn would lessen the use of services. Price controls would force high-cost hospitals either to close or to operate more efficiently. Given the current low occupancy rates for hospitals, however, this policy need not impair access for patients provided the controls apply to all payers. In contrast, if price controls are selectively applied only to patients insured by certain payers, access for those patients might be adversely affected because providers would prefer to treat patients who are exempt from the controls. Under a well-designed, comprehensive system of managed competition, insurers would face incentives to constrain costs. In response, they could be expected to pursue more cost-effective approaches to health care delivery, including systems of managed care. High-cost providers would either find ways to operate more efficiently or see the demand for their services diminish. In some cases, hospitals could be forced to close. As you suggest, however, the populace might accept hospital closings that were the result of cost-based competition among insurers more readily than closings that resulted from what might appear to be arbitrary price controls imposed by the government. CBO has a number of projects under way that assess the effects of alternative health care reforms, and managed competition is certainly one of the alternatives being examined. We expect to release one study on managed competition sometime in the next couple of months. None of our studies examines the issue of fraud and abuse, but the General Accounting Office has recently published several studies in that area: GAO/T-HRD-92-56, Health Insurance: Medicare and Private Payers Are Vulnerable to Fraud and Abuse; GAO-GRD-92-49, Health Insurance: More Resources Needed to Combat Fraud and Abuse; GAO/T-HRD-92-32, Medicare: Contract Oversight and Funding Need Improvement; GAO/HRD-92-69, Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse.

Question 7. In view of the federal government's poor track record in controlling public spending through Gramm-Rudman targets and budget caps, would you expect the task of controlling private spending on health care to be more difficult than controlling the budget deficit?

Mr. Reischauer: During the Gramm-Rudman process, the reductions required by the targets became so large that they were no longer credible, and the law was modified. Ultimately, the deficit targets were abandoned. Similar limitations on national health expenditures could suffer the same fate.

Question 8. Is a global budget compatible with managed competition? In other words, if a global budget is a method for the government to allocate health care resources, and if managed competition is a method to change the way private health plans allocate resources, isn't it contradictory to do both?

Mr. Reischauer: Whether managed competition and overall limits on health care expenditures could be successfully combined is a controversial issue. Some proponents of managed competition think that the two could not be satisfactorily merged, because an important function of managed competition would be to help determine the appropriate level of health care spending through regulated market processes. Other proponents acknowledge, however, that even a well-designed system of managed competition could not guarantee a rate of increase in total health care spending that policymakers would find acceptable. Such proponents have offered different possible responses.

Professor Alain Enthoven, for example, recently suggested how a global limit on health care expenditures might be structured within a managed competition system—that is, if such a limit were considered necessary because the rate of growth of aggregate expenditures otherwise would be unacceptably high.¹ In that case, he suggests focusing on the total premium cost that would be incurred if everyone purchased insurance coverage at the rates for the lowest-priced plans available through their local health insurance purchasing cooperatives. If this total cost grew faster than GDP, the proposed National Health Board could be directed to recommend specific changes—for example, in covered benefits, coinsurance, or premiums—that would reduce health care spending accordingly.

Other people, including some proponents of managed competition, suggest that an expenditure limit would be the most effective way to control aggregate spending on health care. An aggregate spending limit, if it were effective, would imply an average level of spending per person on health care services. A system of managed competition within each region might then be assigned the role of helping to allocate that spending efficiently.² Under this approach, the purpose of managed competition would be to achieve the best health insurance system consistent with that level of spending per person. This strategy would use the expenditure cap as the policy instrument to contain health care costs and managed competition as the instrument to allocate resources efficiently within the health care sector.

Question 9. How much would the government have to lower prices for physician services in 1999 to adjust for volume increases and other sources of “slippage” in order to meet the budget goals of the price control bill?

Mr. Reischauer: If the reduced fees resulted in no changes in volume, we estimate that all prices would have to be lowered about 6 percent. National health expenditures, however, include research and other activities that might not be reduced at all under global limits. If costs in these areas were not reduced, larger reductions would be required in other health spending. Increases in the volume of services delivered by providers whose fees were being reduced could also be a problem. Evidence suggests that Medicare doctors facing reduced rates tend to increase the services they provide to offset about half of the reduction. If this response were to occur, physician fees would have to be reduced by at least 12 percent. We do not know, however, what the volume response might be under a system that attempted to control all prices. The response in those circumstances might be quite different from that experienced in the Medicare program.

Question 10. What would be the growth in national health care expenditures under H.R. 5936 versus H.R. 5502 in 1999?

Mr. Reischauer: Our baseline projection of national health expenditures in 1999 shows a growth rate of 9.3 percent. We estimate that under H.R. 5936, the growth rate in national health expenditures would be reduced by about half a percentage point. Under H.R. 5502, we estimate that the reduction would be more than 1 percentage point.

Question 11. What would be the effect of the Managed Competition Act on Medicare and other government spending?

Mr. Reischauer: We are in the process of preparing detailed cost estimates of both H.R. 5936 and H.R. 5502 that will show the effects of these bills on the federal budget. We are still working on the details of these estimates and will make them available to you as soon as they are completed.

Question 12. In your testimony, you indicate that national health expenditures (NHEs) would fall in response to a cap on the tax exclusion but by an amount less than the reduction in the subsidy. How can you be certain about this conclusion when you are not certain about so many of the behavioral changes that could result from managed competition? Please explain the reasoning behind this conclusion.

Mr. Reischauer: In estimating the effects of limiting the tax subsidies for health insurance, we treated the change as if it were an increase in the effective price of health insurance. We then reviewed the literature on price elasticities for health insurance and health care spending. Although the literature contains a range of estimates, most of them show spending falling by less than the reduction in the subsidy.

¹ See Alain C. Enthoven, “Managed Competition in Health Care Financing and Delivery: History, Theory, and Practice” (revised paper presented at a workshop sponsored by the Robert Wood Johnson Foundation under its Changes in Health Care Financing Initiative, Washington, D.C., January 7, 1993).

² See, for example, Paul Starr, *The Logic of Health Care Reform* (Knoxville, Tenn.: Grand Rounds Press, 1992).

QUESTION SUBMITTED BY MR. KLECZKA

Question. What are the sources of differences in the estimates by GAO and CBO of the savings from adopting a single-payer system?

Mr. Reischauer In its study (June 1991), the General Accounting Office (GAO) estimated that national health expenditures (NHE) would be reduced by 0.4 percent, whereas a Congressional Budget Office study (December 1991) estimated that NHE would be reduced by about 4 percent. These estimates are not comparable, however, because there are significant differences in the characteristics of the single-payer systems analyzed by each study. The GAO study assumed a Canadian-style system, with

- First-dollar coverage;
- Global budgeting for hospitals, with very limited management information systems; and
- No change in the average payments per unit of service.

In contrast, the CBO study assumed

- Coverage with copayment requirements;
- Case-specific payment for hospitals and retention of their extensive management information systems; and
- A reduction in average payments per unit of service using Medicare's rates.

CBO plans, however, to release a paper soon that will have estimates of a single-payer system similar to the Canadian-style plan examined by GAO. Preliminary indications are that the forthcoming CBO results will show an increase in NHE of about 4 percent, compared with GAO's estimate of virtually unchanged NHE. CBO's estimate of the effects of a single-payer system on NHE is expected to be less favorable than GAO's estimate for several reasons:

- CBO's results include the estimated effects of a singlepayer system on all insured services, whereas GAO includes only the effects on hospital and physician services.
- CBO's assumptions about how providers would respond to changes in patient demand are less favorable than those used by GAO. For example, the GAO study assumes that about half of the increased use of services that would otherwise result when first-dollar coverage was introduced would be offset by a reduction in the services provided to other patients. CBO assumes no such offset.
- CBO's assumptions about possible savings in overhead costs for both providers and insurers are more stringent than those of GAO.

QUESTION SUBMITTED BY MR. LEVIN

Question. How much could be saved in administrative costs if the U.S. went to an all-payer system with uniform billing, or just by adopting uniform billing practices?

Mr. Reischauer: Uniform billing would generate approximately the same savings under an all-payer system as it would produce under the current system. We estimate that the savings in providers' billing costs would be about \$6 billion (or 1.5 percent of providers' revenues) in 1991 under an all-payer system with uniform billing and that savings to insurers would be negligible. This estimate assumes that billing costs for providers would fall by 25 percent because of standardized or uniform claims procedures even though providers would still have to bill both patients and a number of insurers for covered services. No change in overhead costs for insurers would be expected, because the current mix of insurers would be unchanged and private insurers would have the same need to market their products, coordinate payments with other insurers, and make a profit.

QUESTION SUBMITTED BY MR. MCCREY

Question. Using the most recent CBO methodology, what would be the annual effect on the federal budget deficit and health expenditures generally of H.R. 5936 from the 102nd Congress and H.R. 200 in the 103rd Congress? I would appreciate these estimates to extend as far beyond the conventional 5 year budget estimates window as possible. Also please assume that the savings and cost effects of the bills begin in FY 1994. Please identify by year, where possible, disaggregated savings and spending effects by each provision in the two bills.

Mr. Reischauer. We are in the process of preparing detailed cost estimates of H.R. 5936 and H.R. 5502. These estimates will show the effects of these bills on the federal budget. As soon as they are completed, we will make them available to you. Because H.R. 200 is very similar to H.R. 5502, it should not take long to complete an estimate of H.R. 200 once we have finished the estimate of H.R. 5502.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman. Dr. Reischauer, I am sure you know that I am not an economist or a physician or a technician, do not understand standard transmissions, and the wheelbarrow is a complicated piece of machinery.

Mr. REISCHAUER. You can assume that you are, though.

Mr. GRANDY. Let me just try and put this whole question into the one that I will try to distill down to my own level of understanding, and it seems to me that what we have to wrestle with is an equation that basically has to say this: Cost, access, quality, and probably choice have to equal value. Otherwise, nobody is going to buy the solution.

And we have had some experience with that, and previous attempts to modify the catastrophic health care bill, which by the way I supported, because I thought it did solve that value equation. But if that is true, then my concern about the global budget strategy is it does not put the burden of proof in the consumer's lap who right now is basing his or her health care choices on volume, not value, through a variety of mixed messages that the market and Government regulation have sent out there. But let me just follow along with that.

I am going to read you something from another piece of testimony I am going to offer later in the day. Since 1986, Congress has passed a series of bills that have dramatically expanded Medicaid health coverage.

States are now required to provide Medicaid coverage to pregnant women and children under age 6 with income up to 133 percent of the poverty level. In addition, beginning in 1991, States were required to phase in coverage of children and families with incomes below 100 percent of the poverty level.

Children age 9 and under must be covered this year, and the age of children that must be covered increases by 1 year each year until he or she reaches age 18 in the year 2000. In addition to these requirements, States have the option of covering women and infants under age 1 with incomes of up to 185 percent of the poverty level.

Now, I am going to give this as part of a defense of a welfare reform package that Mrs. Johnson and I and others are going to introduce by saying that we have moved as a government to expand access, particularly to low income individuals. But any governor that will listen to that will say "talk about a pig in a poke".

Medicaid is one of the huge cost drivers and cost assemblers that they have to deal with. The same with Medicare. If you continue to ratchet down the providers' side, of course, they will design new schemes to expand in service what they have lost in fee. As I look at this, though, it seems to me that the policy decisionmaking for all of us is to try to get the consumer materially involved, more so than the top Government decisionmaking on budgets.

And I guess where I disagree with my friend from Washington, Mr. McDermott, is that if we don't begin there, if we don't begin to force the consumer to choose between value and volume, I don't know how we can do anything, first at the Federal level or either from States, to ever achieve the solution, the equation, getting to the value side.

Now, am I wrong? Have I gotten—am I missing key expertise? Is that too simplistic?

Mr. REISCHAUER. No, it is not too simplistic as a statement of what is desirable and what is efficient in a market economy. The question that we have to answer is whether health care can be subjected to the same rules that apply to other goods and services in a market economy.

The most efficient system for allocating resources would be for the consumer to decide how much to buy. The consumer, however, is constrained by his or her budget, and what we found is that many Americans have budgets that are so low that they cannot afford what our society would regard as a minimal level of health care.

In addition, there is the question of whether people judge appropriately their need to buy health care, because you have to buy it through an insurance mechanism instead of buying it when you need it. And you do not want a situation in which society as a whole will come in and pick up your marbles if you drop them.

Then nobody would buy health insurance. So we have developed this alternative to the individual marketplace—that is called employment-based insurance supplemented by government involvement—but that clearly has not done the trick, as you said.

Mr. GRANDY. But in your response to my question, the basic benefit that society deems appropriate, or words to that effect, isn't that the crux of the argument? I mean this is society, in this room. There is probably a difference of opinion on what the basic benefits should be that would probably be expressed by every individual if we asked them to come to the microphone, and that seems to be one of the things that we have to get into first. Because again, I sense that a lot of people think that a lot of the care that is provided because it is subsidized, that in some cases journals like the New England Journal of Medicine deems inappropriate now, to some extent has to be placed in front of the consumer, and the sad reality is that too many people in this country don't have enough health care and a lot of people have too much, and we are going to have to oblige you to start making choices, and the Government will specify, if we can, what the basic indemnity is, but beyond that, you are on your own.

I mean isn't that a proper role for Government in terms of cost containment?

Mr. REISCHAUER. I think that is the crux of the issue. I think you put your finger on it. It is a political decision. It is not—

Mr. GRANDY. Catastrophe is the word I used. We will have to deny benefits for some people in order to give them to others, and I think that that is a plank that we have got to be prepared to walk.

Thank you, Mr. Chairman.

Chairman STARK. Certainly.

Bob, there is a belief that managed care and managed competition can control national health care costs, so let's start with managed care. Last year you reported that only staff and group model HMOs can be effective in reducing health care costs. I would like to know if this means that after reviewing all the studies and data, you have concluded that what we refer to as IPA model HMOs do not reduce total costs.

Mr. REISCHAUER. Our judgment on managed care is continually changing. We listen to experts that have done recent studies, and we read the new material. The new evidence comes in, and so I do not want to be pictured as saying, group and staff model HMOs work, and nothing else does. But I believe there is no substantial evidence that looser types of managed care—for example, independent practice associations (IPAs)—have been significantly effective in reducing costs.

There is some new evidence that utilization reviews have had an impact, and we have factored that information into our cost-estimating methodology. We will remain flexible on these issues. As you know, studies are being done all the time, and some of them are methodologically sounder than others. We tend to emphasize those results, but we have an open mind.

Chairman STARK. Well, are there no savings then for what I think of as point-of-service plans, preferred provider and a host of other alphabet soup types?

Mr. REISCHAUER. I think our judgment is that the savings from those types of managed care are extremely small, if they exist at all.

Chairman STARK. You further indicated that last year enrollment in the more efficient staff and group model HMOs has not grown rapidly. You also concluded that during the past decade, managed care appears to have had little effect on total health care spending in the Nation. Does this suggest that if we look 8 years down the road, that little savings can be seen from managed care by the end of the decade?

Mr. REISCHAUER. We have to keep in mind that we have gone, over the past 20 years, from a situation in which virtually no Americans were in what is now loosely called managed care to a situation in which roughly 95 percent of the employment-based plans have some form of managed care. To the extent that that might have held down overall costs, it certainly has not held them down to the levels that we want.

Given that virtually everyone is now in some form of managed care, the real issue here is, will the distribution of people shift toward those forms of managed care that seem to be more effective? The point made by Mrs. Johnson, I think, is terribly important in understanding managed care, and that is that there are cases in which this company or that company, by moving to managed care, has saved significant amounts of money because it has basically used its market power over providers to extract a benefit.

That might be an outcome that is only possible because those providers serve many other individuals and corporations and are able to shift the loss from this particular company to others, in the form of higher charges. Then the question is, what have we learned? We might have learned that managed care would be more effective if a uniform type were applied to everybody. We might conclude just the opposite. There is really no way to come out with a definitive answer on that.

Chairman STARK. If my colleagues will indulge me to ask the second part of this in terms of managed competition; it will probably take 5 minutes; I will be glad to wait.

Mr. THOMAS. Go right ahead.

Chairman STARK. Let me go on, and I appreciate your indulgence on this.

In the area of managed competition, your statement notes that even if a managed competition approach with all the critical elements described earlier were carried out, its effect would accrue over an extended period of time. By that, are we to conclude that you mean that a managed competition program would need to include universal enrollment in HPPCs, and basically the complete elimination of ERISA plans with their 50 million Americans now enrolled in them?

Mr. REISCHAUER. To be fully effective, the same set of restraints would also have to be applied to the self-insured plans set up under the Employee Retirement Income Security Act (ERISA). Many of the HPPC proposals involve a shifting of resources across insurance companies to make up for the fact that the various insured pools have different risks and different demographic characteristics. You could not leave 50 million people out of the equation and have the same impact on costs.

Chairman STARK. But they could stay in if the self-insured plan matched all the requirements of an HMO—

Mr. REISCHAUER. No—if it matched the limits that were imposed on the basic plan—and I think that is called for—

Chairman STARK. Do you not also need then an absolutely uniform benefit package with no greater or lesser benefits? In other words, you would not be able to purchase medigap benefits, nor would you be able to buy any extras. It has to be one plan fits all.

Mr. REISCHAUER. You would have to limit the amount of resources that the ERISA plan could provide—

Chairman STARK. I understand. Everybody under managed care—under managed competition don't—

Mr. REISCHAUER. I do not think we have to have absolutely identical provision of services—for example, an HMO would be providing care quite differently from an indemnity plan. There would be an equivalency here.

Chairman STARK. All right. Would you have to include significant taxation of health insurance benefits above some specified amount? Would that be necessary?

Mr. REISCHAUER. You can limit expenditures for these benefits in two different ways. One is to prohibit expenditures above that amount; the other is to provide an incentive to refrain from spending more. The taxation of benefits is the—

Chairman STARK. Would physicians have to be limited to a single plan? In other words, they couldn't move around?

Mr. REISCHAUER. If, as I said in my opening comments, you had the same hospitals or the same physicians in a number of plans, then the competitive element would disappear or would be seriously eroded. This is another aspect of these plans that you have to consider when you try and estimate what the potential savings are going to be.

Chairman STARK. With all this that you have said, the savings wouldn't occur in the extended period of time. I gather by that you mean within the usual 5-year horizon.

Mr. REISCHAUER. We are talking about establishing a completely new institutional structure.

Chairman STARK. About how long? I mean how long is long?

Mr. REISCHAUER. I have no particular insight into this. I think that making the changes and establishing these new institutional frameworks would be a process that would probably begin 3 to 4 years from now and take another 5 years to become fully operational. That kind of timeframe probably applies to virtually all of these plans and to expenditure caps.

We are talking about taking a very large chunk of the American economy—a very important chunk with a large number of actors—and applying a new set of rules to it. And that must be done very cautiously and very carefully, because what we have now is not bad. It costs too much, and it does not cover everybody, but for the vast majority of Americans it provides health care that is unequalled anywhere in the world.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I think that is one of the problems that is in front of us. Some folks believe that cost is the key and that we control it at literally all cost, including doing in some of the positive aspects of our current system, which most people prefer; it just costs too much, and I agree totally.

The point that my colleague from Connecticut made that I want to underscore is that I marvel at folks who do not understand what managed competition means, but apparently fully understand what global budgeting means. Because I have exactly the opposite problem.

As we get into this argument, if in fact we want to use global budgets to control costs, in my opinion, and I think you would agree, it is a marvelous device under the budget rules to produce "savings." Pick a number. I will tell you what it is going to be 1 year from now, 2 years from now, 5 years from now, and the difference between where we are now and where we are going to be to global budgeting are budget savings. I know that is a gross distortion of what you do. But you would come up with—

Mr. REISCHAUER. Yes.

Mr. THOMAS [continuing]. Budget savings if we did that. But it assumes, doesn't it, that for that to work, that the global budget is going to be centrally enforced, rigidly; that obviously, the planning, therefore, has to be uniform and therefore central, and that the services to a very great degree to make it work are going to be driven toward a uniformity as well, or you are not going to get apples compared to apples in terms of cost savings; that is, global budgets force a central control in planning.

Is that a generally agreeable statement?

Mr. REISCHAUER. As I said earlier, for us to score savings for global budgeting or expenditure caps, details have to be provided on exactly how these would work.

Mr. THOMAS. I believe the phrase was a strictly enforced global budget. The gentleman from Washington said that. A strictly enforced global budget is only going to be strictly enforced if it is a top-down hierarchy, centrally planned and dictated budget.

How else do you deal with the term "global budget?" If you are going to have a global budget from the grassroots up, I would advise you that it is pretty tough to determine a priori, OK? So to get it down to a nutshell, it is kind of interesting that the argu-

ment in terms of global budgeting to me sounds a whole lot more like Moscow U. 1948 in terms of models that work, when to appreciate what managed competition is, go to Harvard University 1880s. But most of my colleagues won't go to Harvard in 1880s.

They immediately get bogged down in a managed competition concept of Redd Fox "having the big one" and then having to call up various competing models to decide which one will deliver the best service; that is, all of the weight is going to be on the consumer, which is patently false because of its name, managed competition. And that as you quite correctly pointed out several times that the competition will occur at a number of levels, with the national board, and to the degree we can get them to deposit a model which is not the average Cadillac plan that is currently written because you get a tax writeoff for both the employee and the employer for that model, my assumption is it will be a real model in terms of meeting real needs, not the artificially Tax Code driven needs currently.

You have competition down among the regional plans, and I don't want to get into all the jargon because a lot of people watching don't understand what HPPIs are or the AHPs and the rest of it, but that there is a built-in mechanism which partially relieves the consumer of having to make those kinds of decisions, but which nevertheless provides him or her with the stuff they don't have now: one, comparative information which is useful for shopping, which I think is fundamental, and secondly, some control of their own resources, with an understanding that there are behavioral, tax and economic consequences to the use of those resources.

And when you look at what the changed environment is going to be under a managed competition, true, it is a new concept, but competition started a long time ago. And the irony of all this—this is not a question—the irony of all this is that when we compare the other national models, most of them began to evolve at a time when the central model was not in as much disrepute as it is now.

The forties, the fifties, perhaps Canada as late as the sixties. But if you will look at what most of the centrally planned economies have rejected in the 1980s and the 1990s, they are far more interested in moving into a managed competition, not a peer competition, no one has advocated that. But the irony is when you examine some of those models that evolve during an accepted central planning economic theory period, they aren't anywhere near the global budget models that some of my colleagues are talking about. That when they talk about a strictly enforced global budget, central planning, central controlled, even if you use the British model as I am beginning—the fun of this is, I hadn't planned on being on this committee, so I have learned a lot of new stuff that I hadn't planned on learning, that it isn't nearly as starkly structured from the top down as you might think it would be, given all of the arrows that have been shot at such a system here, there is a degree of decisionmaking at the local level, which is not anticipated in the global budget models that are before us.

Why? Because they have a fundamentally different job to do. Understand, in this country if we adopt global budgeting, it is to ratchet down the cost of health care. In most other systems, be-

cause they evolved earlier, it is not to ratchet down the cost, it is to maintain and control the cost.

And I would say that we have to look at the fundamental reason why central or global budgeting is a concept today. I believe it is primarily driven by the budget rules that we are supposed to operate under, because it is the cheap and easy way to get paper savings and not real world savings, and I hope people will eventually move off of trying to discredit a managed competition model by virtue of placing the consumer in a position which simply does not exist in the managed competition structure.

A lot of details to be worked out. A lot of new relationships to be understood. And, frankly, a lot of cul-de-sacs that we will go down and have to come back and restructure because it is a new model. But it isn't all that novel.

For someone to make a statement that health care cannot be fit into some kind of a managed competition model is to stack the deck in terms of the alternatives.

Chairman STARK. Did you want to associate yourself with—

Mr. REISCHAUER. Did I say that?

Mr. THOMAS. Not at all, and I wasn't directing it toward anyone in particular.

Chairman STARK. Mr. Andrews.

Mr. ANDREWS. Well, it was a great question. I have a question. I really have a short question that I am curious about, because I really do want to submit some questions to you in writing and give you an opportunity to reflect on them.

In trying to come up with a cost analysis of Mr. Stark's bill and this managed competition bill of Mr. Cooper and myself, and in looking at basic plans, were they the same?

Mr. REISCHAUER. You know, in a sense, there is no obvious plan in the expenditure cap-type of bill. Rather, you have a certain amount of money that is available.

Mr. ANDREWS. Right.

Mr. REISCHAUER. And that is a different situation. Now, it might turn out that that amount was sufficient to buy a very Spartan type of coverage. It depends very much on what happens to prices and what happens to the volume of services.

Mr. ANDREWS. Something you said in response to Mr. McCrery, which I think is absolutely right: it depends on how you design this basic package. It could cost a lot, it could cost very little.

You can make it what you want it to be. And I am curious how you, in coming up with your analysis on costs, how do you compare managed competition in a basic plan that you must have devised, because I sure haven't proposed one and there is not one in the legislation.

Mr. REISCHAUER. We used a plan that was the average of what was expected to be provided in 1994.

Chairman STARK. If the gentleman would yield.

Mr. ANDREWS. I would be happy to.

Chairman STARK. HCFA particularly has been, even to me, amazingly accurate in predicting how much the various resources will be used prospectively, with respect to just how many people are going to get sick and how many babies are going to be born and how much costs will go up. We haven't controlled it, but we pretty

accurately have predicted it. I understand what you look at when you analyzed the question of caps. It is just about what we are spending or project to spend prospectively.

I don't know whether it is a good idea or not, but it just took the existing state of medical delivery—

Mr. REISCHAUER. But under an expenditure cap, in a sense we are ratcheting down the level of spending over time, and we do not know what that is going to do. It is conceivable that what it will do is allow the same number of services with the same complexity to be provided, but the providers will receive less money for them. In other words, the incomes of doctors and hospitals would fall.

That is a conceivable response. Another response might be that the pace of technological development slows. Yet another could be more efficient use of existing resources; for example, 20 percent of hospitals in America could close, and the others operate at more efficient levels.

So there are all sorts of responses to the limitation of an expenditure cap. In the managed competition bill, there is a different procedure. There is a board that sets a standard package, and to estimate its impact, somebody has to make an assumption about what is in that package.

We make the assumption that it provides more or less the same kinds of coverage that the average employment-based plan offers now and into the future. And then a series of behavioral responses come into play.

It is conceivable that 20 years from now the quality and quantity of services under the managed competition model would be significantly greater than under the cap proposal. Or it could be the other way around.

Mr. ANDREWS. Right. We just don't know.

Mr. REISCHAUER. We just do not know.

Mr. ANDREWS. In American history in your view, have there been instances where the hard price controls have been very successful?

Mr. REISCHAUER. Only for very short periods of time.

Mr. ANDREWS. And what is a very short period of time?

Mr. REISCHAUER. A few years. We had fairly effective controls during World War II, but those were very unusual circumstances.

Mr. ANDREWS. Can you name another?

Mr. REISCHAUER. We had less effective controls during the Nixon wage and price control era. In a very complex economy, it is quite difficult to control prices. And, as you know, efforts to control prices in the medical care sector elsewhere in the world have resulted in behavioral responses that are not good. For example, if you limit the amount that a provider can receive for a service and you equalize the payment level across all providers, you find—in Canada and in much of Western Europe—that people go to the doctor a lot more often. In other words, there is a volume response.

A doctor here would do in one visit what a doctor in another country might take two or three visits to do. In Japan, there is a system of unofficial gratuities that are provided to the most qualified doctors. Everyone there pays the same price for the same service, which obviously leads to excess demand for the very best doc-

tors. Consequently, around New Year's Day usually, these doctors receive gifts from the patients they have served.

Of course, these are the negative aspects of those systems. The positive side is that everybody is covered and everybody is assured some care. And you are weighing these pluses and minuses when you change the system.

Mr. ANDREWS. Thank you.

Chairman STARK. Thank you.

Mrs. JOHNSON.

Mrs. JOHNSON. I would like to follow up on some of the issues that have been raised. I want to ask you a question on two points and then get to my real question. The question I would like to ask you is would you and your staff draw up a sort of list of what determinations have to be made in order to effectively estimate the impact of a global budgeted system?

[The information follows:]

To estimate the impact of a global budgeting system, we have to know what the global limits are and how effectively they will be enforced. The enforcement question is obviously a difficult one. First, health data collection and coordination must be significantly improved; we must know within a reasonable time frame how much has been spent on health to know whether global limits have been met or exceeded. Second, the rate setters for the system must be able to adjust rates quickly to offset any unanticipated increases in health spending. But even if the enforcement system is well-specified, it will still be difficult to judge its effectiveness because of the lack of experience with such systems in the United States.

Mrs. JOHNSON. Because we have enumerated a number here, you have to make certain assumptions about what the central government will do, or what the State governments will do. If your model assumes the kind of rate setting that we have done in Medicare, when we set individual rates for how many people an anesthesiologist will supervise, then you have to take into account the institutional challenge of setting up this capability at each State level in order to carry forth the bargaining.

If you are not going to set it up at each State level, that impacts the timeframe in which there will be any impact at all for this approach. If you are going to keep it at the Federal level, people need to know that, that your assumption as to savings is driven by your belief that the Federal Government will be able to determine these prices and pass them down to the State level.

Mr. REISCHAUER. There are different ways, though, to implement a cap like this, and you are saying one way is through a regulatory approach, specifying everything in the narrowest detail.

Mrs. JOHNSON. Yes.

Mr. REISCHAUER. Another way is to leave it in the hands of provider groups, as is done elsewhere in the world. For example, with certain of the providers in Canada, a budget is given to them, and they police themselves.

Mrs. JOHNSON. But all I am asking you to do is to say what the alternatives are at this point in your thinking, and what enforcement would have to be in the proposal so that I could be sure that the provider groups were, in fact, going to do that, if that is the mechanism chosen? Because we really have to be able to focus on what is the concrete aspect of the proposal that has to be passed from Washington, if, in fact, we are to maximize the likelihood of an effect.

And that kind of thinking in the global budgets area is not the kind of thinking that has really been done. And I would maintain that the institutional challenge of the Cooper bill has far more precedent of success than the institutional challenge of global budgeting has, because the institutional experience in global budgeting is that we have set prices in public programs only to see the cost shifted because we don't do it very precisely. We set RBRVS reimbursement rates because we are increasing internist reimbursements in my part of the country 20 percent.

I mean that imprecision has to be dealt with in your predictions in your model. And our experience with that at the Washington level is very extensive in price setting and Medicare, and we can document that the rigidities that we built in, that we created the durable medical equipment industry to be a far larger industry than it ever would have been without price setting from Washington.

We make it often uneconomic to do the lower cost noninvasive care, because of the structure of our reimbursement system. So somehow, we have to find a format within which you can lay out the kinds of decisions that have to be made under the rubric of global budgeting for us to understand what decisions we have to make to get the effect those who are in favor of global budgeting want to get and what the cost is going to be, because certain decisions have to be very narrowly circumscribed if you are going to get that cost. So I would ask you to begin looking at that and maybe we can help think through those questions.

Mr. REISCHAUER. I think you have put your finger on a number of important illustrative points. But for my staff to sit down and come up with all of the various decisions that have to be made would take several years—even if we were to use the whole staff, all 220 people. We would have to do everything that is required to implement—

Mrs. JOHNSON. I understand that. Clearly, you cannot do that. I understand you clearly cannot do that. But you can take existing proposals and say this has to be spelled out for us to make an estimate, and if the assumption is this, we can make this estimate. Because we have to get clear on what has to be spelled out.

And we do have some experience in that area that gives us a pretty good indicator of certain issues. But I certainly would say that your answer on the institutional issue and how long it would take to get the managed competition proposal out, I would dissent from you strongly on that.

The kind of board that is proposed, we already have people in charge of outcomes research; that would bring that along. I mean there are a lot of things we are doing. NAIC has a lot of experience with what benefits are on average provided throughout the Nation. I mean we have a lot of experience to do the kinds of things that managed competition requires. We have practically no experience with a national rate-setting system for 14 percent of the economy.

Mr. REISCHAUER. I was not saying that an expenditure cap system could be implemented faster than managed competition at all.

Mrs. JOHNSON. I just wanted to bring up the institutional issues, and I am glad you weren't saying that. I do want to then just dis-

sent, because I want to be sure that this issue of assumptions is clear. On page 1, you say that consumers pay 27 percent of out-of-pocket health care costs in 1980 and only 22 percent in 1991. And later on you claim that consumers are not particularly sensitive to changes in out-of-pocket costs.

Actually, I would say that it is because consumers are sensitive to changes in out-of-pocket costs. And so many employers have now increased out-of-pocket costs that we see an overall decrease, because there is a big reaction to this. People are so sensitive that it is not popular, and that is why we are having trouble with the out-of-pocket cost issue. So I would draw exactly a different conclusion than you would from those figures.

Mr. REISCHAUER. People do not like to have things taken away from them, if that is what you mean.

Mrs. JOHNSON. That is right.

Mr. REISCHAUER. What we are talking about here is increasing the share of the premium that is paid by the employee, and, of course, the share that is paid out of after-tax dollars. Nobody wants that, and they complain when it occurs.

Mrs. JOHNSON. Of course.

Mr. REISCHAUER. Once that money is paid, though, they are as insensitive as they were before to the cost of the services that are provided through the insurance package. You can make them more sensitive by increasing the deductible, although the deductibles are extremely low and have not kept pace with incomes or inflation over time. In fact, they have been falling in relative terms.

Changing the coinsurance rate from 20 percent to 25 percent is an option, but if you stop and think about the increase in the overall price of the service that the individual is actually paying, it is often relatively small.

Mrs. JOHNSON. It is just that our failure to be able to change those amounts, and generally that is true, there has been an increase in employees taking premiums.

Mr. REISCHAUER. We do not want to do it too much, because we do not want to discourage people from getting necessary medical care. This is the dilemma that we face as a society.

Mrs. JOHNSON. The real reason is because people don't want them increased, and there is opposition from people, don't increase my copayments.

Mr. REISCHAUER. And there is the perception that this is something that is being given to you by your employer, not something he should be trying to take out of your back pocket.

Mrs. JOHNSON. That is right. I think it proves that consumers are sensitive, not that they are not sensitive. They are so sensitive that they rise up in rebellion against this. We are talking about two different things.

Mr. REISCHAUER. The problem here is that when we talk about expensive medical care, on which a great deal of the money is being spent, the consumer is often in no shape to make an informed decision. For complicated procedures, patients do not say, no, I do not want this, I am going to go to the Kmart supplier.

Mrs. JOHNSON. I don't want to spend any more time on it. Thanks. I get your point and you are right. But it leads into the next question—

Chairman STARK. Is this your last question?

Mrs. JOHNSON. This is my last question. But if you would like to leave, it is all right.

Chairman STARK. I have a bunch more.

Mr. REISCHAUER. I am going to have to leave, because I have to go back to my office and get testimony for the next hearing.

Mrs. JOHNSON. Your testimony on page 2 about managed care is interesting. "Managed care can reduce inappropriate or unnecessary health care." And since inappropriate or unnecessary health care is very big bucks, that matters.

And yet, you then from every sentence thereafter imply that they really can't do much; they might reduce hospital use a little bit. Now, first of all, to me the value of managed care, and I bring this up because, see, again, maybe we are looking at the wrong criteria. Maybe your criteria for estimating the impact of a managed care system ought to be its structure.

Is it a structure that will assure that outcomes, research, guidelines, preventive care knowledge gets fed in and utilized rapidly and constantly? Then you get that continuous improvement in the reduction in inappropriate and unnecessary services.

So maybe your criteria ought to be, we can't estimate the cost of managed care unless you tell us more about how it is going to be structured. Will it be structured in such a way that it uses this knowledge? Will it be committed to that knowledge? Because the difference between a PPO—one of the differences between an individual provider organization and a more tightly knit group is this level of communication and agreement on how technology is to be used and what is to be done under what circumstances. So I consider structure to be almost more important than name.

Mr. REISCHAUER. I think you are correct and that all of these elements are tied together. But what I would like to point out is that the alternative to inappropriate or unnecessary care often is not no care; it is appropriate, effective care, which may or may not be more costly than the inappropriate, ineffective care. Most people are receiving care—

Mrs. JOHNSON. I mean those words cover a lot of duplicate testing, a lot of unnecessary surgery, a lot of invasive surgery when noninvasive treatment could be used; don't you agree?

Mr. REISCHAUER. I agree, but it is certainly not just the sum of the inappropriate or unnecessary care, because, as I said, some of that would be offset by other—

Mrs. JOHNSON. Yes, certainly, but a managed care system, particularly a cap-tied payment, you know, the big motivation—

Mr. REISCHAUER. You are right; that is why the group and staff model HMOs would show the greatest reduction in hospital care and produce the greatest saving.

Mrs. JOHNSON. I hope you won't get too hung up on HMOs. As a representative of a district in which there are not very many, there are a lot of group practices whose hospital use numbers are far lower than the HMOs in the area whose cost per patient is lower are being solicited by companies that want them to cover their people because their statistics are all so good.

So I think we have to be careful. I think we have to be using some sort of coordinated system of care terminology, rather than

linking it in people's minds to any one specific type of provider. Because it is a question of structure, it is not a question of name. And group practices are sometimes structured far more effectively than HMOs to accomplish those goals.

Mr. REISCHAUER. What you really want to do is look at the incentives that the provider has to economize on services. Capitation types of systems, in which the provider has an incentive to limit procedures, are more effective than other types of systems.

Mrs. JOHNSON. It certainly can come in other forms.

The last thing, I would urge you to be sure to keep abreast of what the insurers are doing in this area, because they are now into the second or third generation of change in the concept of managing care.

You said earlier in your testimony—

Mr. REISCHAUER. I was looking at that 2 weeks ago.

Mrs. JOHNSON. This is the last word, Mr. Chairman. That there is no example of managed competition. Absolutely, there is.

We created managed competition in defense in order to cut costs and improve quality and we achieved both of those goals. So when we created a second provider, a competitive source, when we managed the competition between them by making G.E. give Pratt & Whitney their engine designs and vice versa. I mean, we have some experience in structuring competition and even to the extent of a far more managed system than this implies.

Mr. REISCHAUER. I do not mean to be flip about this, but I would suggest to you that the airline industry before deregulation was also a variant of managed competition.

Chairman STARK. Imagine this committee riding herd over a budget twice that of the Defense Department. That sounds like fun.

I would like to pursue a couple of things. I will try and go through them quickly, if you could respond, Bob, and give me a few more minutes.

In the taxation of health insurance benefits, how would a tax on health insurance benefits lead to reductions in health care costs? Could workers just drop the peripherals, mental health, dental, prescription drug, and have those been such a major problem area?

Mr. REISCHAUER. Taxing premiums above a certain level could lead to any one of three responses, and whether it would affect national health expenditures or the extent to which it would depends on how that response came about. It could be that if employees decide just to pay the tax, Federal revenues would go up, and there would really be no change in national health expenditures for all practical purposes.

Second, employees could choose to go into health insurance plans that were not taxed because they were below the threshold level and provided a smaller group of services or greater cost sharing in some form. That choice would reduce the demand for services and probably lead to lower national health expenditures.

Third, employees could choose more effective, efficient service delivery mechanisms, such as group or staff model HMOs, that would provide the same level of services but at a lower cost. Under this approach, the national health expenditures would fall but not total services, which might even increase. One would expect that as the second of these reactions occurred—that is, as people chose indem-

nity plans but with lower benefit levels—the less essential types of services would be lopped off first, including eye care, prescription drugs, glasses, and dental care, which, by and large, are not large components of national health expenditures now and are not paid for in most cases by health insurance. So there is not a lot of leeway to do that.

Chairman STARK. Wouldn't a program that taxes health benefits or insurance benefits above some amount create unfairness for those, for instance, who live in high-cost areas or are in firms with a lot of older workers, or in areas with older—

Mr. REISCHAUER. Well, certainly, if we instituted a tax of that sort without changing the structure that exists now, there would be a great deal of inequity. You would have a situation in which small firms that already pay a lot more than large firms for an equal type of insurance would be hit, as would the workers in those firms. The workers in firms that had excessive-risk pools—construction, mining, and the like—would also be hit.

So there would be substantial inequity and other reasons to think that it would not be an advisable policy. However, if we had a restructured health care system—for example, under a managed competition proposal in which there was redistribution across insurers, depending on the risk of their covered populations—these concerns would disappear. That threshold under the managed competition bills, I believe, is set by area, so high-cost areas would have higher tax thresholds than low-cost areas.

Chairman STARK. So what you are suggesting is we would end—

Mr. REISCHAUER. That kind of tax would be a rather unusual feature of our tax system.

Chairman STARK. We are fighting about that with the District of Columbia right now. We would like to talk to you about that.

Mr. REISCHAUER. I believe in no other area of our formal Tax Code do we have geographically specific thresholds.

Chairman STARK. In that same vein, my guess is that most of the burden would fall on middle-class households with income between \$20,000 and \$60,000. Would this be fairly characterized as a tax on the middle class?

Mr. REISCHAUER. If we imposed it under the current system, it would be a tax on those who have expensive, employment-based health insurance. Remember, the employee segment of premiums is already subject to tax, is already taxable income, and what this would be is a lot of—

Chairman STARK. Say that again? The employee—

Mr. REISCHAUER. If you were required to pay \$20 of the health care premium and your employer pays \$300 a month, the \$20 that you are paying comes from taxable income. Changes in that amount would create behavioral response. It is the other segment—the employer payment—that is important.

By and large, I would not characterize it as a tax increase but as a reduction in a tax expenditure that has benefited individuals and families who have expensive health care coverage provided by their employer. Most of these people work for large companies or perhaps for government and therefore are middle class.

But this reduction would also apply to those who work for law firms, advertising firms—high-wage firms that provide very good benefits.

Chairman STARK. I don't know if you want to comment on what you think we would save with what is referred to as malpractice reform.

Mr. REISCHAUER. Malpractice reform involves very small amounts of resources. I believe the total premiums for malpractice insurance are something less than 1 percent of total national health expenditures. So even if we could wipe that segment out, we are not really dealing with the problem.

Now one could argue about defensive medicine, which is a whole other subject, but I think, by and large, that the estimates of defensive medicine have been overstated.

Chairman STARK. What kind of savings could you look for out of what is referred to as practice guidelines, practice parameters or whatever term you want to ascribe to those?

Mr. REISCHAUER. I do not have an estimate of those savings. I will be glad to see what we can find for the record of the hearing. [The information follows:]

We consider the development, dissemination, and implementation of high-quality clinical practice guidelines to be important components of strategies to ensure that health care dollars are spent appropriately and effectively. Those strategies become increasingly important as we attempt to constrain health care spending. We do not, however, assume that reducing the variation in medical care utilization through greater use of guidelines would result in lower national health expenditures.

We have reviewed the literature on the effects of implementing clinical practice guidelines and discussed the issue extensively with several of the leading experts in the field. Because inappropriate care includes underuse and misuse of medical services as well as overuse, the widespread adoption of medical practice guidelines might result in the increased use of some services and in reductions in the use of others. The net effects on health expenditures are unclear.

Nonetheless, continuing efforts in the public and private sectors to develop and implement practice guidelines appear to be warranted. If such initiatives were successful, they could: Improve the cost-effectiveness of medical expenditures; reduce the excess use of some diagnostic and surgical procedures; reduce the risk of undertreatment in health care plans that have incentives to decrease utilization; help to protect providers against malpractice liabilities; and provide policymakers with guidance for allocating limited health care resources and determining the minimum benefits to be guaranteed under different health care reform proposals.

Chairman STARK. There is an issue of making patients be cost conscious. If individuals pay more out-of-pocket, the argument goes we would be more aware of costs. And you, I think, stated that a 40-percent increase in out-of-pocket payments would only have a small impact on the use and cost of health care.

I am paying about \$100 a month, \$95 for the Blue Cross option to be specific. What you are saying is if I had to pay \$140 a month, I would still pay it. Is that correct?

Mr. REISCHAUER. Well, particularly if the increase came in the form of a higher premium. The increase would not change your decisions once you needed medical care; that is, the parameters of the system would be unchanged.

By and large, studies have shown that consumers are relatively unresponsive to increases in out-of-pocket costs, even nonpremium-related costs. Part of this is that many of the decisions that we make to consume are really done on the advice of the provider. We regard ourselves as poor judges of the necessity for a certain proce-

dure or treatment, or of the alternatives. Nor do we have the faintest idea, often, of the price.

Chairman STARK. Or what the procedure is.

Mr. REISCHAUER. I have questioned my doctor about this since I began testifying regularly and have found that he has no idea of the cost of the services that he is providing to me.

Chairman STARK. I will try the test on you. Do you know what you pay each month for your health insurance? You are under the Federal plan as I am, I believe. What is your share of the premium each month?

Mr. REISCHAUER. I confess ignorance. I tend not to deal with numbers under a billion dollars.

Chairman STARK. Is it an indemnity plan?

Mr. REISCHAUER. Yes. It is the same one that you have. I heard that the risk pool was good, so I decided to get into it.

Chairman STARK. You see, this is my contention. The experts know approximately the cost of their plans, generally about \$80 or \$90. However, when you ask about specific benefits like, do you get 85 or 75 percent of the hospital bill if I call first or if I don't call first, and how many benefit days am I allowed? I mean sooner or later very few of us could outline all the specifics of our health plans.

Mr. REISCHAUER. Remember, when you are in the ambulance, take your cellular phone.

Chairman STARK. Last question. I have been interested in the use of a single claims clearinghouse for the payment of all bills. Will a single claims clearinghouse improve the effectiveness, save us money, or improve our efficiency?

Would the use of a single clearinghouse system improve private sector savings? And do you know how much or what they would be?

Mr. REISCHAUER. I do not have a specific number for you, but a clearinghouse certainly would generate savings because it would simplify billing practices significantly. But it also would be important for another reason, and that is that it would be a point at which information could be collected on utilization.

Chairman STARK. Contemporaneously.

Mr. REISCHAUER. Yes, contemporaneously, but in other ways as well. When you have a multipayer system, there is virtually no way that you can gather utilization data by provider in an efficient way without imposing a morass of requirements on the providers. So this would be a good source of information-monitoring, evaluation-type research.

Chairman STARK. Thank you.

In closing, all I can say is hang in there. To your patient staff, thank you all for your work.

The committee is adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

ECONOMIC IMPACT OF RISING HEALTH CARE COSTS

TUESDAY, MARCH 2, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:35 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, FEBRUARY 25, 1993

PRESS RELEASE #3
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM:
THE ECONOMIC IMPACT OF RISING HEALTH CARE COSTS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing to examine the impact on the economy of rising health care costs.

This will be the third of a number of hearings on health care reform which will be held by the Subcommittee. This hearing will be held on Tuesday, March 2, 1993, beginning at 10:30 a.m., in the main committee hearing room, 1100 Longworth House Office Building.

In announcing this hearing Chairman Stark said: "President Clinton, in his State of the Union address, described how rising health costs and the lack of coverage are endangering the economy, with a devastating impact on the deficit and on family budgets. In response to the President's call for action, this hearing will examine the consequences of rising health care costs. National health spending, now at over \$900 billion, is consuming an increasing share of the nation's gross domestic product (GDP). The increase in health care costs consumes a large and growing share of workers' compensation; it makes health insurance unaffordable for many families, and creates anxiety among American families that illness will result in financial ruin."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

The economic impact of rising health care costs is realized by Federal and State budgets, corporations, and workers and their families. Health care costs are increasing rapidly, at more than 12 percent a year, more than 8 percent above the rate of general inflation. By the year 2000, national health spending is expected to reach 18.9 percent of the GDP.

Rising costs are driving up health insurance premiums by more than 15 percent each year. At the current rate of increase, health insurance premiums will double every four years.

According to a recent study by the Congressional Budget Office, employer-provided health insurance absorbed more than half of the increase in workers' real compensation between 1973 and 1989. Although businesses initially pay a major portion of the costs of employer-provided health insurance, these costs are ultimately shifted to employees in the form of lower wages and reduced non-medical fringe benefits.

The rise in health care costs has become a prominent issue in labor/management negotiations, and the lack of agreement over this issue has led to a number of strikes. In many cases, corporations have restructured health benefits in order to reduce costs.

This hearing will focus on the impact on the economy of rising health care costs, rather than consider options for reform. The Congressional Budget Office will present expert testimony on the economic implications of rising health care costs. In addition, representatives from the labor and business communities will present testimony on the impact of rising costs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, March 16, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will ~~not~~ be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. Good morning. The subcommittee will hold its third hearing on health care reform.

The President has emphasized that health care costs and lack of coverage present a danger to the economy and the financial security of our families. This hearing will examine some of the consequences of increasing health care costs.

Skyrocketing health care costs consume a large share of workers' compensation. There is no question that increasing health care costs are reducing the take-home pay of America's workers.

The rise in health care costs has become a prominent issue in negotiations between labor and management and the increase in health costs has resulted in restrictions in health benefits which would have been unthinkable only a few years ago. In some cases, employers have resorted to decreases in coverage for their workers and outright termination of coverage for dependents and retirees.

It would be an omission of some magnitude if I did not mention that in just the past few days in the great State of California—from which the Ranking Minority Member and I come—that the Bank of America, which serves one out of two families in California, has taken some 18,000 employees and put them into an hourly part-time status which will prohibit them from getting health care benefits.

These individuals are mostly women, with average salaries below \$20,000. While it could save the Bank of America \$70 or \$75 million, the issue is that there may be several thousand more Californians who will have coverage unavailable to them. I am sure that the economic consequences of this decision can be imagined by all of us.

[The opening statement of Chairman Stark follows:]

Opening Statement

The Honorable Pete Stark

HEALTH CARE REFORM: THE IMPACT ON THE ECONOMY
OF RISING HEALTH CARE COSTS

March 2, 1993

Good Morning. Today the Subcommittee is holding the third in a series of hearings on health care reform. I hope that these hearings will lay the foundation needed to help us work with our new President to enact a comprehensive health care reform plan.

In his State of the Union address, President Clinton emphasized how health care costs and lack of coverage endanger the economy and the financial security of our families. This hearing will examine the serious consequences of unabated, rising health care costs, in response to the President's call for action.

Let me emphasize that this hearing is focused on the problem of rising health costs, rather than on solutions. We will, of course, direct our attention to the solutions once the White House submits its health reform plan to the Congress.

The rise in health care costs is felt at every level in the U.S. economy. It contributes to the growth in the Federal deficit, and is a growing share of State, corporate and family budgets.

Skyrocketing health care costs are consuming a large and growing share of workers' real compensation. There is no question that increasing health care costs are reducing the take-home pay of America's workers.

The rise in health care costs has become a prominent issue in negotiations between labor and management. The increase in health costs has resulted in restrictions in health benefits which would have been unthinkable only a few years ago. In some cases, employers have resorted to decreases in coverage for their workers and outright termination of coverage for dependents and retirees.

There is also evidence that employers are shifting from full-time to part-time work schedules in order to avoid altogether the issue of the rapidly rising cost of health benefits.

A health reform plan that effectively controls increases in health spending will have obvious benefits for workers, employers, States and the Federal government. It would allow businesses and families to invest in other priorities, without sacrificing the security of health coverage and without reducing the quality of care.

Controlling health care costs is an important part of any strategy to assure our nation's international competitiveness. American businesses and workers cannot wait five or ten years while Washington continues the debate that already spans more than 6 decades. They need real reform and they need it now.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I would ask unanimous consent my full opening statement be placed in the record.

Chairman STARK. Without objection.

Mr. THOMAS. I thank the Chairman.

As we focus on the macroimpact of the health care discussion, and as this subcommittee considers alternatives for reducing the Nation's health care bill, it is important to remember that quick fixes generally come with unanticipated and frequently unwanted effects. To be frank, health reform, despite its mandate, may produce changes totally unacceptable to the American people if we are not careful. Obviously, we need to address some broad concerns in this system but we need not to rush to judgment. We need to get it right the first time. Arbitrarily constraining prices does not give the providers of health care any new tools to fight costs but it does give a good argument for the political marketplace that Government is acting for the consumer by squeezing the spendthrift rich hospitals and doctors.

The President and the Congress can take that line to the American people and say you wanted to reduce health care spending, we did it for you, no one suffers but the inefficient, dishonest and overpriced providers. That is, in fact, a quick fix and not a permanent one.

Mr. Chairman, in addition, we know from experience what price controls will and will not do to our economy. If the controls are allowed to remain intact for any length of time, they will reduce the effectiveness and the efficiency of one-seventh of this Nation's economy, or what is more likely, the controls will become a political football to be kicked around for the benefit of every Member of the House of Representatives and the Senate.

We are going to hear from a number of groups that universally will point the finger at someone else. I really do not see any long-term value in attempting to blame someone else for the problem. As is often said, there is plenty of blame to go around. I hope that testimony today will begin to provide some opportunities to look at solutions, not short-term quick fixes but long-term fundamental re-directing so that all Americans can benefit from this exercise.

Thank you, Mr. Chairman.

Chairman STARK. I thank the gentleman for his opening remarks. And I don't mean to be contentious, but it was the intention of the Chair to deal today just with the economic consequences of the increase of cost, not to portend that there are not a variety of suggested solutions to the health care crisis. The gentleman's remarks are well taken, but I did not want to have him offended by the absence of any approach to solutions in today's testimony.

Mr. THOMAS. If we could solve the problem in one hearing, it would be blessed. It is obvious that will not be the case. There will be a number of hearings. I think you will find, however, that even at this hearing, in looking at the economic costs or the macroimpact, that you will have one group blaming one group and the other group blaming the other group.

Chairman STARK. Just so they don't blame us.

Mr. THOMAS. Just so they don't blame us, which is where the bulk of the problem lies.

[The opening statement of Mr. Thomas follows:]

**STATEMENT OF THE HONORABLE BILL THOMAS
MARCH 2, 1993**

The hearing today addresses the effect of the growth of health care spending on individual Americans as well as our national debt and economy. There is little question that the growth in health care spending is taking an undue toll on the paychecks of individual Americans both as purchasers of health care and taxpayers.

However, as the Health Subcommittee considers alternatives for reducing the nation's health care bill, it is important to remember that the quick fixes generally come with unanticipated and frequently unwanted effects. To be frank, health reform, despite its mandate, may produce changes totally unacceptable to the American people if we are not careful. We should not forget that "some cures are worse than the disease." So, as we identify the problems facing health care in America, let us not rush to judgement, and seek the quick fix.

Mr. Chairman, it is my concern, that this hearing, and the broader media campaign which has been launched against the drug industry and probably soon against other providers and insurers, sets the stage for a simplistic cost containment strategy, a quick fix. The "quick fix" in this case is federally mandated price controls for all medical services.

Unfortunately, the American public too often seeks others to blame for its troubles. Politicians are often too ready to take advantage of this "blame the other fellow" attitude by scapegoating. In health care there are many potential scapegoats for the politicians to identify. The task of passing the blame is made all the easier because our health care system, albeit the best in the world, is ripe with inefficiencies, fraud and abuse, high income providers, and the burden of a misdirected legal system.

So, it is simple to take the health care spending formula -- price times volume equals total spending -- and conclude that all the problems of spending can be solved by holding down prices. And then, let the doctors and the hospitals figure out how to contain costs.

Arbitrarily constraining prices does not give the providers any new tools to fight costs. But, it gives a good argument for the political marketplace that government is acting for the consumer by squeezing the spendthrift, rich hospitals and doctors. The President and the Congress can take that line to the American people and say, you wanted to reduce health care spending, we did it for you and nobody suffers but the "inefficient, dishonest and overpriced providers."

Well Mr. Chairman, such a solution will only be simple on the day the legislation is enacted, and the press releases are distributed. The next day and every day thereafter, we will all have to pay a political and economic price for the results.

Mr. Chairman, we all know from experience what price controls will and will not do in our economy. If the controls are allowed to remain intact for any length of time, they will reduce the effectiveness and efficiency of one-seventh of this nation's economy. Or, what is more likely, the controls will become a political football to be kicked around for the benefit of every member of the House of Representatives and the Senate.

Our political system is well suited to provide the exception to every petitioner who comes through the door. And, in the case of health care there will be many who seek redress under the imposition of mandated price controls.

With price controls each of us on this Subcommittee will become inundated with pleas for help from all the providers in

- 2 -

our districts. Worst of all, the entire focus of health care pricing will be concentrated on how to play the Congress or the federal bureaucrat. And, who can argue it will be more rational for them to join in that game rather than figure out how to produce good health care more cost effectively.

This Ways and Means Committee has seen this reaction by providers in the Nixon era price controls and in Medicare. The rural hospitals, the teaching hospitals, and those hospitals harmed by national rates, have all sought redress. I would even suggest that Medicare's pricing schemes would have become even more onerous for the Congress to administer, if the hospitals and doctors did not have the other payers upon which to pass the high cost of treating the elderly and disabled.

The cost shift has given the policy makers and the providers an easy out. If price controls leave no room to shift, we will all pay the price.

There is another way, instead of setting up schemes to assign prices, this Subcommittee can take a serious look at the cost drivers and the disincentives in the current health care system which inhibit efficiency. We could focus our attention on reforms to give the individual American, hospitals and doctors, the tools to change, to make better decisions and to reduce their costs.

This Subcommittee has learned that such alternatives may not win points in the Congressional numbers game, as arbitrated by our estimators, but, these approaches will enable those who receive, provide, and pay for health care each to contribute to making the system truly more affordable. Isn't that what our constituents sent us here to do?

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

Just briefly, I think at today's hearing we will hear testimony that will usefully try to undermine some of the misconceptions often brought to this field. There is a tendency to try to fit the solutions into our own ideological frameworks.

I just want to say that, to Dr. Reischauer, you do a good job challenging some of the myths. I just want to express my hope that in destroying or taking on some of the myths, we don't create others.

And I want to ask you very vigorously about your conclusions that might lead some to think that health care costs are irrelevant to U.S. competitiveness. Because I think that when you go industry by industry, that health care costs do impact on their specific competitiveness, but I will save that for the questions.

Thank you.

Chairman STARK. If none of my colleagues has comments for the record, we will begin with Dr. Reischauer, who is Director of the Congressional Budget Office.

Bob, we are pleased to welcome you back to the subcommittee and look forward to your testimony, as with all of our witnesses today. Your entire printed statements will be included in the record, and we would encourage witnesses to expand on that testimony or enlighten us in any manner in which they are comfortable.

Lead on.

STATEMENT OF ROBERT D. REISCHAUER, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. REISCHAUER. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to be here to discuss with you the economic implications of rising health care expenditures. I will submit my prepared statement for the record of these hearings, and I will spend the next few minutes summarizing a few of the points that are in that statement.

My message this morning is really quite simple: rising health care costs have a very significant impact on the American economy, but this impact is misunderstood by many Americans, who labor under a number of misconceptions about the causes and economic consequences of rising health expenditures.

Unless the American public gains a better understanding of the economic forces underlying the current health care system, reform measures are likely to be either misguided or woefully inadequate. Let me describe what I regard to be three of the most prevalent misconceptions.

The first involves confusion about who is paying the tab under the current system. Many Americans appear to believe that the 65 percent of total costs that they do not pay directly in the form of insurance premiums, out-of-pocket spending, or Medicare taxes and premiums is being borne by somebody else.

Workers seem to believe that the health insurance they receive as a fringe benefit does not cost them much because their employers pick up an average of about 80 percent of the premium costs. Nothing could be further from the truth.

Economists have concluded that, in the long run, workers, not businesses, bear most of the costs of employment-related health insurance. They bear this cost in the form of lower real wages and reduced nonmedical fringe benefits. CBO has estimated that the growing costs of health insurance absorbed a bit over half of the increase in real compensation per full-time employee between 1973 and 1989. This squeeze on real wages has meant that workers had less to spend on everything else and have felt their circumstances quite strained.

The widespread misconception that businesses, not workers, are shouldering the bulk of the costs of employment-related health insurance has fostered two other misunderstandings. The first is that rising health insurance costs have made it difficult for U.S. companies to compete in the world marketplace. But if escalating health premium costs are reducing cash compensation and nonmedical fringe benefits, not raising business costs, this cannot be the case.

The second misunderstanding is that employment-based insurance must be financed in a fairly progressive fashion, much of it coming out of profits, maybe of corporations. But if workers eventually are bearing most of the costs that are initially paid for by business, the true burden within a single firm might look more like a highly regressive head tax.

A second broad area of misconception involves inflation in medical prices. The general perception is that much of the increase in health care spending comes from the rampant growth of medical care prices, a growth that only serves to fatten the profits of health care providers. If medical inflation could be curbed, some argue, spending could be brought under control with little effect on the quality and quantity of medical care that Americans receive.

Unfortunately, we know very little about the magnitude of pure price increases in the medical sector because our inflation measures are seriously deficient. The medical care component of the CPI, for example, does not measure the total cost of medical care but only consumers' out-of-pocket expenses, which have declined significantly over the last 30 years. In 1960, for example, 56 percent of personnel health care costs were out-of-pocket costs, but in the last year for which we have available data, the figure was only 22 percent.

Moreover, medical price indices measure intermediate outputs such as the cost of a day in the hospital rather than the final product, which would be the cost of treating a particular disease. Thus, when technological improvements reduce the length of hospital stays or allow a disease to be treated in a cheaper outpatient setting, the economies are not adequately reflected in our price indices, even though they may reduce the consumer's total cost for treating a particular illness.

Similarly, the prices in the CPI are generally list prices and do not reflect the growing importance of discounts that many patients now receive through their health care plans. But most important is probably the fact that the CPI does not adequately adjust for the dramatic improvements that have taken place in the quality of medical care over recent decades.

This is a terribly difficult thing to do, and our price indexes are deficient in their ability to cope with quality changes across the

board. But since quality change is probably so significant in the medical arena, this flow has more importance there. The bottom line is that efforts to curb costs through rigid price controls could significantly affect the quality of care that is available to Americans.

A third widespread misconception many Americans have is that some modest modifications in the current health care system could effectively control spending and free up the resources needed for significant reforms to improve access. Managed care, malpractice reform, and administrative simplifications have all been championed on these grounds.

While some savings could be realized in each of these areas, the dividends are likely to be modest in size and quite difficult to achieve. For example, national health expenditures might drop by as much as 8 percent—less than 1 year's increase—if everyone were enrolled in a staff or a group model HMO, which seems to be the most cost-effective form of managed care that is out there. However, most Americans do not consider such HMOs to be an attractive alternative to their current form of health insurance.

Similarly, malpractice reform may well be a desirable thing to carry out, but it is unlikely to have a large effect on either the level or the rate of growth of health care spending. One reason is that malpractice premiums represent less than 1 percent of national health expenditures. Another is that the savings from a reduction in defensive medicine practices, which are widely thought to be the real cost of our malpractice system, may be rather modest because many of the procedures and tests that are characterized as defensive medicine now would probably be undertaken for other reasons, and different services would be substituted for many of those that were dropped. Furthermore, it is important to realize that the threat of malpractice suits may act to improve the quality of medical practice in this country. So there is a positive dimension to the malpractice problem.

Administrative costs could be reduced substantially if we developed a single-payer health care system. However, claims that such administrative savings would total \$100 billion or more a year are greatly exaggerated. CBO's estimates suggest that potential savings in administrative costs from a single-payer system are more likely to be around \$30 to \$35 billion.

It is also important to keep in mind that our system of copayments, deductibles, and utilization reviews is in part responsible for the high administrative costs that we face. But these dimensions of our current system tend to reduce overall health care spending and, in many ways, can be viewed as substitutes for the explicit rationing and supply controls that countries with lower administrative costs use to keep health spending in check.

Let me conclude by saying a few words about health care reform and the budget deficit. While it is true that the deterioration that CBO projects in the budget outlook after the mid-1990s is almost entirely attributable to the continued escalation in Medicare and Medicaid costs, it does not follow that health care reform will bring Federal costs down in the short run or even in the intermediate term.

There are several reasons for this. First, reform is likely to involve expanded coverage for the uninsured, many of whom will need substantial Federal subsidies to obtain coverage. Second, the Federal Government may realize few near-term savings from reduced cost growth if health care reform involves some leveling of the reimbursement playing field. Currently, payment rates for public and private payers differ substantially, with public programs paying substantially less than the private payers, and one would expect that this differential would be narrowed under a reformed system.

Having cautioned you not to expect savings in the near term, let me underscore that health care reform is essential if we are to improve the budget and economic outlook in the next century. The sooner we act, the sooner we will realize the long-term gains we all know are there. The main reason, however, for undertaking such reforms is that currently we have no control over health care spending, neither a market control that balances spending on health against other kinds of purchases in the marketplace, nor an administrative control such as many other advanced countries have that does the same balancing through the political process. Indeed, right now we have no process at all for deciding how much to spend on health, and we all suspect that we spend too much. Reform will have to address this issue.

That completes my summary, and I will be happy to answer any questions that the subcommittee members might have.

[The prepared statement follows:]

Statement of
Robert D. Reischauer
Director
Congressional Budget Office

Mr. Chairman, I appreciate the opportunity to appear today before this Subcommittee to discuss the economic implications of rising health care costs.

The United States spent 14 percent of its gross domestic product (GDP) on health care in 1992, more than double the proportion devoted to health care as recently as 1965. Unless current trends are altered, either in government policies or in private behavior, spending on health care will grow to 19 percent of GDP by the year 2000 (see Table 1).

TABLE 1.
PROJECTIONS OF NATIONAL HEALTH EXPENDITURES, BY TYPE OF SPENDING

Type of Spending	Selected Calendar Years								
	1965	1980	1985	1990	1991	1992 ^a	1993 ^a	1995 ^a	2000 ^a
	Billions of Dollars								
Hospital	14	102	168	258	289	321	351	421	644
Physician	8	42	74	129	142	156	171	205	309
Drugs, Other Nondurables	6	22	36	56	61	66	71	83	117
Nursing Home	2	20	34	53	60	67	75	91	137
All Other	12	64	110	179	201	222	244	290	425
Total	42	250	423	675	752	832	912	1,089	1,631
	Average Annual Growth Rate from Previous Year Shown (Percent)								
Hospital		14.2	10.4	8.9	11.8	11.4	9.3	9.4	8.9
Physician		11.5	12.1	11.7	10.2	9.6	9.9	9.5	8.5
Drugs, Other Nondurables		9.1	10.8	9.0	9.0	8.2	8.1	7.9	7.2
Nursing Home		17.9	11.3	9.3	12.4	12.1	11.4	10.2	8.5
All Other		12.0	11.4	10.2	12.0	10.8	9.9	9.0	7.9
National Health Expenditure		12.7	11.1	9.8	11.4	10.7	9.6	9.3	8.4
Memoranda:									
Gross Domestic Product (Billions of dollars) ^b	703	2,708	4,039	5,522	5,677	5,943	6,255	6,942	8,627
Average Annual Growth of Gross Domestic Product (Percent)	n.a.	9.4	8.3	6.5	2.8	4.7	5.2	5.3	4.4
Ratio of National Health Expenditures to Gross Domestic Product	5.9	9.2	10.5	12.2	13.2	14.0	14.6	15.7	18.9

SOURCE: Congressional Budget Office.

NOTES: n.a. = not applicable. Details may not add to totals because of rounding.

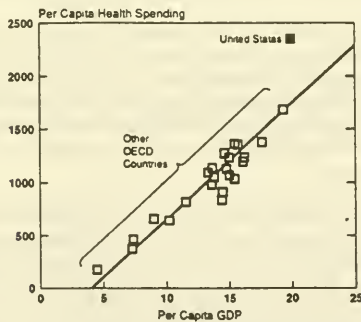
a. Projected.

b. Economic assumptions reflect the Congressional Budget Office baseline of January 1993.

Should we be concerned about such dramatic increases or that the nation spends nearly twice as much on health care as it spends on education? After all, dramatic structural changes have been a familiar feature of our country's economic development. Growth in incomes, differences in the rates of advances in productivity among industries, and the opening of the economy to world trade can all bring substantial changes. For example, over the past 40 years, agriculture's share of gross national product (GNP) has fallen from 7 percent to 2 percent, while the productivity of American farmers has soared. Over the same period, the share of income spent on all services (not just health) has also gone up relative to that spent on manufacturing, simply because the productivity of services has grown more slowly. Furthermore, in a free marketplace such as ours, allocation of resources primarily reflects consumer preferences. For example, the share of income consumers devoted to airline travel increased two and one-half times during the 1965-1990 period in which the share going to health care "only" doubled. And not surprisingly, in this rich country, people place a high value on good health and high-quality medical care.

Yet, compared with other industrialized countries, the United States spends a much greater proportion of GDP on health than would be expected from its per capita income (see Figure 1). But surprisingly it does not appear to have a substantially healthier population. Moreover, although there are some good reasons to expect health care spending to be important in our society, the large and continually rising proportion of national income going to the health sector is cause for considerable concern to many economists and policymakers. Behind that concern stands the realization that health care is not provided in a truly competitive marketplace and, therefore, the resulting spending may not reflect the preferences of either consumers or society.

Figure 1.
Health Spending and Income in Countries
of the Organization for Economic
Cooperation and Development, 1989



SOURCE: George Schieber and others, "Health Care Systems in Twenty-Four Countries," *Health Affairs*, vol. 10, no. 3 (Fall 1991), pp. 7-21.

NOTES: Health spending and gross domestic product are converted to dollars using purchasing power parities. Per capita gross domestic product is expressed in thousands of dollars. Per capita health spending is expressed in dollars.

Several factors distort the efficient workings of the health care market. First, the prevalence of health insurance insulates consumers from the full cost of health care, which leads to an excessive use of covered medical services. Second, informational obstacles make the market work less efficiently. Treatment costs--both total and those not covered by insurance--are difficult to obtain in advance, and comparison shopping can be costly and impractical for many sick people. Third, the technical nature of many medical services makes consumers poor judges of the appropriateness and efficacy of alternative treatments, leading them to delegate decisionmaking to the provider, who has an incentive to provide more services from the standpoint of both professional training and economic self-interest.

Another reason for concern is that the escalating cost of health care has exacerbated the problem of access that, given the high cost of care, depends crucially on having insurance. Growing numbers of the nonelderly lack health insurance in part because soaring premiums have reduced the availability of employment-related insurance; individual policies have also become prohibitively expensive for many people of modest means, particularly those with health problems.

The dual problems of high and escalating costs and inadequate access have convinced many Americans that fundamental reform of the health care system is necessary. But the debate over what direction these reforms should take has been both contentious and confused. Part of the difficulty stems from some widespread misunderstandings that exist about basic economic aspects of the current health care system. These misconceptions have distracted and misdirected much of the debate on reform. Unless they are dispelled and the American public and policymakers gain a better understanding of the economic forces underlying the current health care system, policies for reform could prove to be either misguided or woefully inadequate.

WHO PAYS FOR HEALTH CARE?

The first of the pervasive misconceptions involves confusion about who is paying the tab under the current system. Many Americans believe that a substantial portion of the costs of health care is being borne--not by the American consumer, worker, or taxpayer--but by some ill-defined third party. That conviction makes the public reluctant to consider directly bearing the full costs of a reformed system even when those costs are no more than those of the current system.

Americans are, of course, well aware of the 35 percent of health spending they themselves pay for directly in the form of insurance premiums, out-of-pocket medical expenses, and Medicare's Hospital Insurance (HI) taxes and Medicare premiums. But they often act as if the less visible 65 percent is manna from heaven. For the nonelderly, the majority of whom receive health insurance as an employment-related fringe benefit, the prevalent belief is that this insurance does not cost employees much because employers initially pick up an average of about 80 percent of the premium costs. Nothing could be further from the truth.

In the long run, workers--not businesses--bear most of the costs of employment-related health insurance in the form of lower real wages and reduced nonmedical fringe benefits. The growing costs of health insurance have absorbed a large portion of the recent increase in total compensation

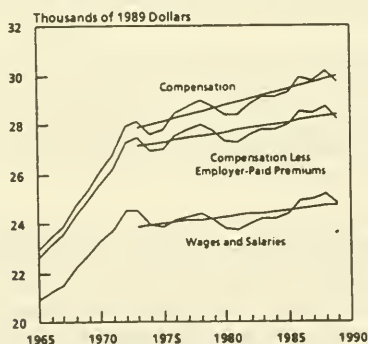
(wages, employer payroll taxes, and fringe benefits). Between 1973 and 1989, both years in which the economy was operating at close to full capacity, employers' contributions to group health insurance absorbed more than half of the increase in real compensation per full-time employee, even though it represented 5 percent or less of the total (see Figure 2).

This squeeze on real wages has meant that workers have had less to spend on everything else—particularly frustrating for wage earners who have had trouble making ends meet. These frustrations have probably added to tensions between labor and management as well.

The widespread misconception that businesses, not workers, are shouldering the bulk of the costs of employment-related health insurance has fostered two other misunderstandings that have muddled the debate on health care reform. The first of these is that the rising cost of employment-based health insurance makes it difficult for U.S. companies to compete in the world marketplace. In fact, health insurance has little long-run effect on the competitiveness of U.S. companies, regardless of how much health care costs go up, since workers bear most of these costs.

I do not want to imply, however, that health costs have no effects on businesses. Clearly, because wages and prices do not adjust immediately to changes in the economic environment, unexpected increases in costs can temporarily affect employment, profits, and international competitiveness. Furthermore, certain firms, such as those with abnormally high health costs for retirees, may find themselves at a disadvantage because they might have a difficult time shifting such costs onto their current labor force.

Figure 2.
Inflation-Adjusted Compensation, Health
Premiums, and Wages per Full-Time
Employee: Actual Data and 1973-1989 Trends



SOURCE: Congressional Budget Office based on data from the Department of Commerce, Bureau of Economic Analysis.

NOTE: Deflated by the consumer price index for all urban consumers.

The belief that workers bear only a small share of the costs of employment-related health insurance has also fostered the notion that this insurance must be financed in a fairly progressive fashion--much of it coming out of profits. But to the extent that these costs are shifted back to workers in the form of reduced wages and salaries, quite the opposite is the case. Within a single firm, the burden looks much like a regressive head tax because the health insurance premiums that a business pays for its highly paid executive and its low-wage custodial worker are much the same. In this context, almost any financing alternative--even a payroll tax or a tax on consumption--is likely to be more progressive than the current system.

The misconceptions of Americans about how health care is paid for are not restricted to employment-related insurance; they extend to the 45 percent of the total that government pays for as well. Although most workers feel the sting of the payroll tax, and beneficiaries are familiar with the monthly Medicare premiums they must pay, these costs are but the tip of the iceberg.

At the federal level, an additional \$39 billion in general revenues was spent subsidizing Medicare in 1992, and \$116 billion more was needed for Medicaid, veterans' health benefits, and other health programs. State and local governments spent roughly \$123 billion more on health-related activities in 1992.

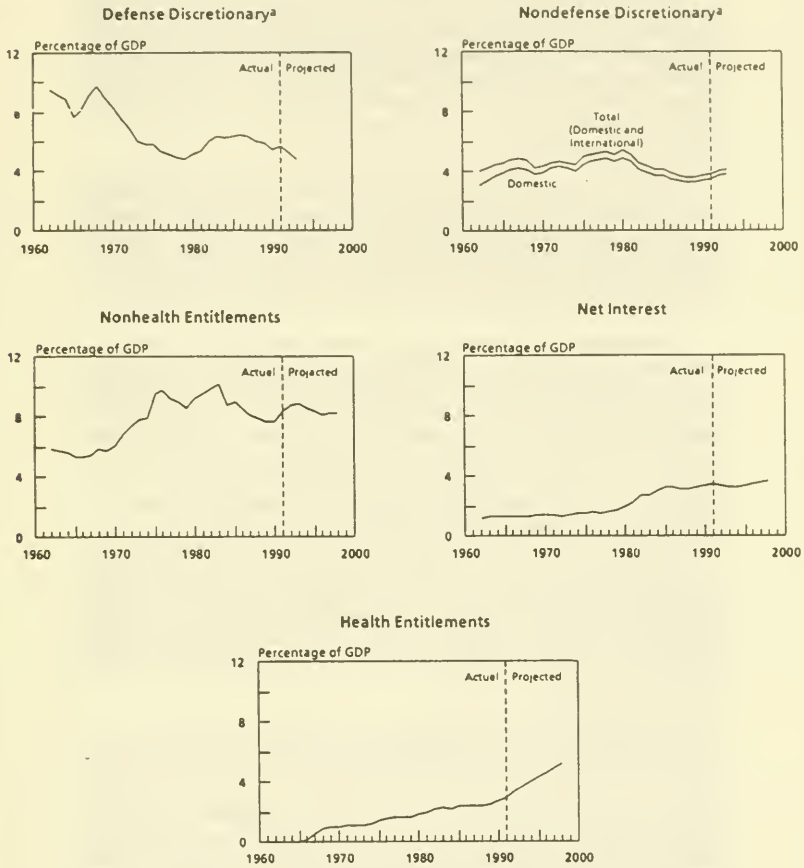
Over the past decade, health care has been the fastest growing major component of government budgets, absorbing resources that could have been devoted to other needed services, deficit reduction, or tax relief (see Figure 3). If current policies are not changed, the past will be prologue, and other priorities will again be sacrificed to the relentless increase in spending by the public sector on health.

The skyrocketing costs for Medicare and Medicaid will translate into larger budget deficits if the projected increases in federal health spending are not offset by increases in taxes or cuts to other federal spending. Under current law, however, federal tax revenue is expected to remain at roughly 19 percent of GDP and, although the share of nonhealth spending will fall, it will not fall enough to offset the expanding share for health care.

The Congressional Budget Office (CBO) projects that, if policymakers do nothing, the federal budget deficit will increase from its current level of about \$300 billion to about \$650 billion in the year 2003. And even with the spending cuts and tax increases proposed by the President (but without any health reforms), the deficit would still be around \$300 billion in 10 years by the Administration's calculations.

Foreign capital will be needed to finance such huge deficits. Moreover, as exports of government debt grow, exports of U.S. goods and services will be crowded out. By pushing up the exchange value of the dollar, the budget deficit will raise the costs of U.S. goods on world markets. Thus, because rising health costs add to the federal budget deficit, they have a significant effect on the competitiveness of all U.S. businesses--both those that provide health insurance for their employees and those that do not. These effects, however, stem solely from the budget deficit, not from increases in the cost of employment-based health insurance.

Figure 3.
Federal Outlays as a Share of Gross Domestic Product



SOURCE: Congressional Budget Office.

NOTE: GDP = gross domestic product.

a. Assumes compliance with discretionary spending caps in the Budget Enforcement Act. Caps are not specified in detail after 1993.

WHAT IS DRIVING UP HEALTH COSTS?

A second area of misunderstanding and misconception involves inflation in medical prices. The general perception is that much of the increase in health care spending comes from the rampant growth of medical care prices that only serve to fatten the profits of health care providers. If medical inflation could be curbed, so the argument goes, spending could be brought under control with little effect on the quality and quantity of medical care that consumers receive.

This perception is perpetuated by statistics that have recorded a relentless rise in the prices of medical care. For example, over the decade from 1982 through 1991, the medical care component of the consumer price index (CPI) rose at almost twice the rate of the overall CPI (7.9 percent versus 4.1 percent). But the measures of medical prices that the public is bombarded with are seriously flawed. The CPI for medical care, for example, does not measure the total costs of medical care, but only the consumer's out-of-pocket expenses, which have declined significantly over the past 30 years. Moreover, medical price indices measure intermediate outputs, such as the cost of a day in the hospital, rather than the final product, which would be the cost for treating a disease.

Thus, when technological improvements reduce the length of hospital stays or allow a disease to be treated in a cheaper, outpatient setting, the economies are not adequately reflected in price indices though they may reduce the consumer's total costs for treating the illness. Similarly, the prices in the CPI are generally list prices and do not reflect the growing importance of discounts that many patients now receive through their health plan.

Most important, however, the CPI does not adequately adjust for the dramatic improvements that have taken place in the quality of medical care over recent decades. New, more accurate diagnostic tools such as Magnetic Resonance Imaging and amniocentesis are now routine. Less invasive and less risky surgical techniques are now the norm. Although these improvements have generally pushed up spending, it is impossible to disentangle the portion of those cost increases that reflect higher prices without undertaking the nearly impossible job of accurately measuring the improvement in quality that has taken place.

The bottom line is that we just do not know how fast medical prices are rising, and efforts to curb costs through rigid price controls could significantly affect the pace at which qualitative advances take place. Hence, cost controls are likely to be more painful than many envision, requiring consumers to accept some real limits on the quality or quantity of medical care that is available.

ARE THERE ANY SILVER BULLETS TO CONTROL COSTS?

A third widespread misconception that has influenced the reform debate is the notion that by modifying some aspect of the health care system, spending could be effectively controlled and the resources needed to address the access problem could be freed up without adversely affecting the quantity or quality of care received by consumers. Managed care, malpractice reform, and administrative simplifications have all been championed on these grounds. Certainly, some savings could be realized from each of these areas, but the dividends are likely to be modest in size.

Managed care is a key component of many reform proposals; it is argued that this form of delivery will eliminate unnecessary and inappropriate care, saving substantial costs without forcing consumers to give up beneficial services. Certain approaches--staff and group model health maintenance organizations (HMOs)--have shown that they can significantly reduce health care use and costs. Some other forms of managed care seem capable of achieving modest cost reductions as well, but the evidence on their effectiveness is mixed.

However, most Americans do not consider such HMOs an attractive option, and many of the proposals for reform rely on looser forms of managed care. If everyone could be cajoled into enrolling in a staff or group model HMO, national health expenditures could drop by as much as 10 percent, and insurable personal health care spending could drop more than 10 percent. Although substantial, that amount represents roughly one year's increase in health care spending. Thus, although managed care could lower the level of current health expenditures, it probably would not affect the long-term growth of those costs.

Reforming the medical malpractice system is another strategy for controlling costs, and it shows up frequently in proposals for health reform. Changing this system may well be a desirable thing to do, but it is unlikely to have much effect on either the level or rate of growth of health care spending in the nation. Overall, malpractice premiums amounted to less than 1 percent of national health expenditures in 1991. Many argue that the indirect costs of our malpractice system, which have been labeled defensive medicine, are where the large savings would be realized.

The evidence on the extent of defensive medicine and its effect on spending, however, is limited and uncertain. Many of the procedures and tests that are characterized as defensive medicine would probably be undertaken for other reasons, and different services would be substituted for many of those that were dropped. Moreover, the threat of malpractice suits may have improved the quality of medical practice in the nation.

Eliminating administrative waste is a third cost-cutting strategy, one that advocates of a government-run, single-payer health care system argue will pay for much or all of the expansion of services implied by a national health insurance system. To be sure, administrative costs are far higher in the United States than they are in many other countries. However, the potential administrative savings that would result from substituting a single-payer system for the current system with its thousands of insurance carriers and individual billing practices have often been greatly exaggerated.

Unrealistic assumptions and weak data are behind the appraisals claiming that more than \$100 billion could be saved on insurance administration and providers' administrative costs. More conservative estimates, including those produced at CBO, suggest that potential savings in administrative costs from a single-payer system are more likely to be around \$30 billion to \$35 billion.

Contrary to popular impressions, some of the so-called "administrative waste" may indeed be reducing overall health care spending. For example, the system of copayments and deductibles that drives up administrative costs at the same time makes consumers more sensitive to the prices of the services they receive. Utilization reviews also add to the cost of administration, but they do attempt to reduce unnecessary care. Such administrative costs can be viewed as substitutes for the explicit rationing and supply controls that countries with lower administrative costs use to keep health spending in check.

There are no easy or painless ways to control health care costs--spending less means that revenues to providers are reduced and that consumers receive fewer and a different mix of services and amenities. Effective control over costs would almost certainly involve giving up some aspects of our current system that many people find desirable, such as rapid access to new technologies, freedom of choice of provider, and extensive research and development.

WILL HEALTH CARE REFORM REDUCE THE FEDERAL BUDGET DEFICIT?

Many Americans believe that effective reform of the nation's health care system will help to control federal health care costs in the next few years. The Administration projects tentative deficit reductions from health care reform of about \$200 billion at the end of 10 years.

Yet, the notion that reforming the system will quickly yield significant savings on the spending side of the federal budget is probably optimistic. Fundamental reform of the system is obviously essential if the growth in health costs is to be stemmed in the long run. But in the short run--say, over the next 10 years--it will be exceedingly difficult to realize significant budgetary savings as long as any reform proposal extends coverage to the uninsured, reduces the high costs facing privately insured people, and maintains all of the other desirable aspects of the current system. That is a tall order.

The uninsured currently number about 35 million people and, although they have access to some medical care now, the uninsured, on average, receive about 50 percent to 70 percent of the medical care provided to people who are fully insured. Reform is likely to seek to eliminate this disparity. But unless the insured population is willing to accept less care, raising the level of care available to the uninsured will boost overall health costs. The net increase in national health spending of providing the uninsured with coverage similar to private insurance policies could be about \$33 billion in 1994. Furthermore, if reform exempts the uninsured from the copayments that are common in most private policies, national health spending could increase by about \$50 billion by 1994. Someone will have to pay these additional costs.

The services now received by the uninsured are paid for through various mechanisms. Most hospitals are able to recover the bulk of these unreimbursed costs through subsidies from state and local governments, other nonpatient sources of revenues, and surplus revenues (or profits) from private payers. Surplus revenues from private payers accounted for more than half of the recovery of unreimbursed costs.

This pattern is reflected in the relative reimbursement rates among different payers. In 1990, hospitals were able to charge roughly 28 percent more than their treatment costs for private patients, even though private payers at the same time were making many efforts to control their hospital spending. By contrast, hospitals received payments that were only 80 percent of estimated costs for Medicaid enrollees and 90 percent of estimated costs for Medicare enrollees (see Table 2).

TABLE 2.
HOSPITAL REVENUES AND COSTS, BY PAYER OR OTHER SOURCE, 1990

Payer or Other Source	Revenues		Costs		Ratio of Revenues to Costs
	In Billions of Dollars	As a Percent-age of Total	In Billions of Dollars	As a Percent-age of Total	
Total	210.6	100.0	203.2	100.0	1.04
Medicare	69.8	33.2	78.0	38.4	0.90
Medicaid	18.4	8.7	23.0	11.3	0.80
Other Government Payers	3.4	1.6	3.2	1.6	1.06
Uncompensated Care ^a	2.5	1.2	12.1	5.9	0.21
Private Payers	104.1	49.5	81.6	40.1	1.28
Nonpatient Sources ^b	12.4	5.8	5.5	2.7	2.25

SOURCE: Congressional Budget Office estimates using data from Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (June 1992).

NOTE: The underlying data are from the American Hospital Association's *Annual Survey of Hospitals* for 1990. They correspond to hospitals' fiscal years ending during calendar year 1990.

- a. Uncompensated care is defined as charity care plus bad debt. The revenues shown are operating subsidies from state and local governments.
- b. Includes operating revenues and costs from sources other than patient care, such as profits from cafeterias and gift shops, plus nonoperating revenues such as contributions, grants, and earnings on endowments.

If health care reform involves a leveling of the reimbursement playing field so that payments by all public and private payers more closely follow costs, the federal government may be able to realize few of the savings from reduced cost growth in the near term. Successful health care reform should improve the efficiency of the nation's health care system and, by focusing providers on cost control, may be able to generate significant cost savings over the long run. But if the savings from health care reform are used first to cover the uninsured and then to reduce the high costs of private payers, not much will be left to reduce the costs of the federal programs.

Of course, some reform options could increase federal tax revenues significantly. Taxing the employer-paid portion of health insurance, for example, could raise \$262 billion over a five-year period. But ending the tax subsidy for health insurance could also raise the number of uninsured.

Although health care reform may not bring budgetary benefits in the near term, it will surely help improve the budgetary and economic outlook in the next century. The main reason for undertaking such reform is that we currently have no control over health spending—neither a market control that balances spending on health against other kinds of purchases in the marketplace nor an administrative control, such as many other advanced countries have, that does the same balancing through the political process. Indeed, right now, we have no process at all for deciding how much to spend on health.

Moreover, with no such decisionmaking process, there is a strong presumption that 14 percent, rising to 19 percent and beyond, is too much of our national income to spend on health. Thus, although health care reform may not solve the nation's problem with the budget deficit, policymakers may

still judge it a success if it could cover the uninsured, reduce the costs to privately insured patients, and maintain high-quality care.

CONCLUSIONS

Should policymakers be concerned about the rapid growth in health care costs? There are many reasons to answer yes. First, health care markets are not truly competitive and therefore do not work very well. Because health care spending does not have to meet the usual market tests, health resources are not allocated in ways that reflect either individual or social preferences. As a result, the nation's health system is prone to spend too much money on tests and procedures that have too little value.

Second, rising health care costs have significantly reduced many people's access to medical care and seem to be creating a dual system of medical treatment in the United States. Although most people enjoy access to the best and latest care in the world, an increasing number of people are shut out.

Third, rising costs place significant burdens on workers. Wages and salaries are lower because more compensation is taken in the form of health insurance. And labor markets are distorted by the complex rules of employment-based health coverage. Because the costs of insurance are now so high, the availability of health insurance is becoming a more important factor in choosing a job.

Fourth, rising health costs have also put substantial pressures on government budgets. Health programs are gobbling up a large portion of government resources and are threatening to crowd out other priorities, too. At the state level, increases in Medicaid costs will make it more difficult for states to fund other programs or provide tax relief. At the federal level, health spending is the only category of the budget, with the exception of net interest, that is rising as a share of GDP. These budgetary pressures make it difficult for policymakers to deal with the nation's gargantuan federal budget deficit, which diminishes the economic prospects of the nation's children and grandchildren.

Whether the nation wants to undertake a fundamental restructuring of its health care system or tinker around with incremental reforms is a decision that is yet to be made. Fundamental health care reform is a difficult and complex undertaking, one that would involve a good deal of redistribution and some wrenching institutional restructuring.

We are only in the initial stages of considering the issue. Beginning the debate with a clear understanding of the current system--how it works, its strengths and weaknesses, its economic ramifications--will increase the odds that health reform, as it eventually develops, will not be based on misconception and misunderstanding and therefore will be successful.

Chairman STARK. Thank you. I think we are going to get into this discussion a little bit, and I think subsequent witnesses may question your assessment that health costs will affect the wages of employees. I think too many employer actions basically hurt the wages of employees. For those that did not have their insurance canceled, the rest of them paid higher premiums. And while I don't know that it prevented anybody from buying computers, they ended up saving a lot of money on medical care costs.

But how would you respond to the view that health costs limit the ability of employers to invest resources that could be used to improve productivity and ultimately profits? In other words, they are going to contend that rather than having this affect wages, it will affect investment and productivity resources. How do you deal with that?

Mr. REISCHAUER. My assessment is really a broad-based judgment for the economy as a whole. There are certainly instances in which firms cannot pass the costs of insurance on to their employees. The most notable situation would be the firm that faces a large bill for health care for its retirees that is competing with other firms that don't face this kind of burden. That would characterize the auto industry. And in those kinds of situations, the costs will be borne by profits and will reduce the ability of firms to invest and modernize.

Chairman STARK. On the other hand, in the service industries, it would almost all come out of wages; right?

Mr. REISCHAUER. For services that don't face any international competition, that would be true.

Chairman STARK. Or don't have much in capital investment. I mean janitorial services.

Mr. REISCHAUER. When you begin talking about services like that, you find that very, very few of them offer health insurance to their employees.

Chairman STARK. That is true.

Mr. Thomas.

Mr. THOMAS. There are a lot of strong feelings, Mr. Reischauer, as was heard by some of the opening statements. I am hearing from folks that are saying that what you say is simply not the truth. It is interesting how we shift from one side attacking and the other defending, depending on what you print from week to week.

I am not comfortable on the defending side, so I won't do it very long, but do you have any information that looks at compensation to the employee? And it may have to be by industry, because clearly you have indicated those that make a product have a squeeze; and those that offer a service don't. And that looks at the past 35 years, at the total compensation packages, which is the way an employer has to look at it, wage plus fringe.

Can you make any statement about that total mix? Is it higher or lower or is it simply where the line is divided between wage and fringe, and that because both the employer and the employee can pass it on to the unnamed bank holder through the tax structure, that there has been more inclination to go fringe because you can get more bang for the buck out of fringe than you can out of straight salaries?

What about the total package? Has that been shaped by the health care question on the fringe benefit side in terms of tax writeoff or has it merely been the relationship between wages and fringe within an overall compensation package? Do you have any evidence to indicate that at all?

Mr. REISCHAUER. The employer can write off wages paid as well as fringe benefits paid, and he is interested in looking at the total compensation that he has to pay for an additional worker. That, at the margin, is how he makes a decision.

The costs of health insurance could be pushed forward in some markets in the form of higher prices back in the form of reduced cash compensation, or could affect profits. But, in a sense, the impact on profits would be relatively temporary because capital will move out of those industries in which the rate of return is less than the competitive rate.

Mr. THOMAS. On page 5, you indicate that over the past decade, health care has been the fastest growing major component of Government budgets, absorbing resources that could have been devoted to other needed services, deficit reduction or tax relief.

Why are businesses or corporations not like Government, that is, a larger piece of the pie being absorbed by the increased costs in health care, denying them the opportunity to do other things; planned expansion, capital intensive modifications, hire more people? Why are they not like Government in terms of a squeeze on their overall resources? Or are they the same?

Mr. REISCHAUER. Because they have an ability to shift the costs onto either workers or consumers. And to the extent that they can, they will do that.

Mr. THOMAS. Do they have another shift available through the Tax Code?

Mr. REISCHAUER. From the individual's standpoint, this is a form of compensation that is favored in the sense that it is not subject to taxation. From the standpoint of the employer, the advantage of this form relative to other forms would be nonexistent for the simple reason that employers can deduct cash wages—

Mr. THOMAS. This is a corporate point of view. Whether taken in wages or fringe benefits is not a significant decision. The assumption is that because of the enormous increase in the fringe benefit portion of the package over the last decade or two, it must have been driven by someone, and the assumption is that it was the worker that drove the mix of that package. Is that a fair assumption?

Mr. REISCHAUER. The worker is receiving income in a tax-free form, and that is what has been going on, I think.

Mr. THOMAS. So the mix is largely shaped by those who receive the benefit from it; and if there is a perceived greater benefit in one form versus another, they will assume more of that form, which is a fringe benefit that is a tax writeoff.

My concern also, and I am running out of time on this first ground, is that one of the problems is there is an enormous inequity out there between those who have in the private sector and those who don't, and those who are losing, as indicated by the Chairman's comments.

Is there enough out there in the total pie that by a more appropriate distribution of the benefits you can find a major portion of the solution to the problem? Do you understand my question in a shorthand way?

Mr. REISCHAUER. Yes. I think nobody is arguing that we don't spend enough on health care in this country. Relative to other countries, we are off the charts. So the amounts of resources that we have, if we could distribute them more equitably, should be sufficient. But that involves a tremendous amount of redistribution, and it involves taking resources or income away from certain providers in the system or certain individuals who may have quite adequate health care.

Mr. THOMAS. My colleagues have often heard the refrain we ought to soak the rich; that there ought to be a redistribution of the health wealth in this country; take it from those who have a greater share of it under the tax benefit that has been the main driver for the last several decades and use that, that is, deny the tax writeoff benefit or a portion thereof, and redistribute it.

Redistribution of wealth is something that they are very familiar with and is a key component in most of their arguments. And I am going to find it ironic, if we are talking about income, they are all for soak the rich, but somehow they don't want to continue that pattern when we talk about the total health care resources.

One more question. More often than not the public sector tends to have—public employment sector tends to have a significant package of health care benefits vis-a-vis the private sector. It is spotty there.

Do you believe that more and more people are not only making decisions about whether they work in the private sector but whether they work in the public or private sector driven by health care costs?

Mr. REISCHAUER. Well, speaking only about the Federal health care system, I think you would find that it is below average for large employers. If we were talking about firms that hire 10,000 or so employees, the average firm would have a more generous package than Federal employees are provided. Now, that is not true for some local governments. Some local governments have very generous plans.

Mr. THOMAS. So the large, large-employer analogy would be something like Bank of America.

Mr. REISCHAUER. I don't know what their specific plan is, but the auto workers' plans, for example.

Mr. THOMAS. Have you heard of any government unilaterally canceling insurance for its employees?

Mr. REISCHAUER. I have seen reports of very small units of government doing that, but no major—

Mr. THOMAS. I think, once again, as with pensions and other areas, we have to talk about public versus private and the balance between the two as we look at the overall picture in terms of health care.

Mr. REISCHAUER. But I don't think you have seen any large corporations cancel their policies either. What you have seen them do is ratchet up the fraction of the total cost that is paid by the workers directly with after-tax income.

Mr. THOMAS. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Just a word to my good friend and colleague, Mr. Thomas. The Democratic approach, our approach, is not based basically on redistribution, but rather on economic growth. A major problem with the proposal to vigorously tax health benefits is that it would not be a shift from very wealthy taxpayers but primarily from middle-income taxpayers. That is the group that would bear most of the weight of that proposal, and there will be testimony showing that.

But let me just zero in, Dr. Reischauer, on your comment on page 4 about competitiveness, because I think knowing you, as you try to put myths in their place, as I said earlier, you don't want to be misunderstood.

There is a blanket or general statement there on page 4, in fact: Health insurance has little longrun effect on the competitiveness of U.S. companies. But you hint further in your testimony that that is a macrostatement; that there may be exceptions to that, and I don't think we want to leave any misunderstanding on that.

Let me just read to you from Henry Aaron's comments on this and just see if you basically agree with him. Starting on page 95 of his book, "Serious and Unstable Condition," he says, in general, relatively high average health costs have little or no effect on overall—and that is in italics—U.S. competitiveness. Companies with health care costs higher than the U.S. average may suffer some competitive disadvantage.

And then he goes on to say on page 98: The automobile industry is the prime example. Both high wages and generous health care benefits reflect the considerable market power the automobile unions enjoyed for many years, and that the combination of high insurance costs growth, or as part of total cost of compensation, will reduce the capacity of such companies to compete not just with imports but with other domestic companies. Some companies can offset high health care costs by reduction in other wage costs while some cannot.

And then on page 100 he repeats this: In summary, high and rapidly growing U.S. health care costs do not much affect—that is qualified—overall—in italics—U.S. international competitiveness, but they may influence the composition of U.S. exports-imports, and then he goes back to automobiles—I think he could be talking about steel and other industries—saying that labor costs and costly health insurance benefits for both active workers and large obligations to retirees no doubt add to the difficulties American automobile companies face in competing with foreign-owned companies.

Now, is there anything in those statements that you disagree with?

Mr. REISCHAUER. No, there is not.

Mr. LEVIN. So when you say that it has little longrun effect on the competitiveness of U.S. companies, you are talking about overall?

Mr. REISCHAUER. Overall, and I tried to make it clear in my answer to the previous question. With respect to certain companies that have large retirement health care obligations or that have extremely generous plans in combination with higher-than-average

cash wages and nonfringe benefits, that is not the case. Those companies that have higher cost structures will have higher prices.

Mr. LEVIN. I just want to be sure that in the generalization of your testimony, the urgency in particular instances is not lost.

You know, there is a saying, don't lose the forest for the trees. I am afraid your testimony might lead some people to lose the trees for the forest. I mean, there are industries where the high inflation and health care costs do impact their competitiveness. And I just want to tell you, if I might, what I think is the practical dynamic not only in the auto industry but in many others, and that is that when a structure is built, expectations are raised. I don't think in most cases unreasonable expectations. Workers wanted health care somewhat similar to those received by the employer. And once that structure is developed and the expectations are gained, there is not total elasticity.

And you cannot simply say, well, it is taken from the wages. Because, again, you have created a structure and a structure where people who are blue collar and lower echelon white-collar workers have decent health care benefits, and that is part of the industrial pattern. Without it, we would be in worse shape in this country in terms of health care coverage.

So I just fear that your kind of generalized, conceptual, kind of cerebral, academic conclusion will miss the point. How about that? I don't expect you to—

Mr. REISCHAUER. I am devastated. I don't know if I will be able to recover today.

Mr. LEVIN. Those were all meant as compliments. Thank you.

Chairman STARK. Mr. Andrews.

Mr. ANDREWS. I have no questions, Mr. Chairman.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Reischauer, in your testimony you indicate that if we could tax employer-paid health insurance, we could raise some \$262 billion. What is your assumption as far as the rate of taxation to generate that vast amount of money?

Mr. REISCHAUER. I think what we are talking about there is simply subjecting employer-paid health insurance to the income and payroll taxes, but at the same time giving back a certain credit to allow—

Mr. KLECZKA. For low income?

Mr. REISCHAUER [continuing]. Everybody to purchase some health insurance but with less of a subsidy—not an open-ended match from the Federal fisc. It is an option that is included in our deficit reduction volume.

I might add that—

Mr. KLECZKA. Would that be along the lines of the Heritage proposal for vouchers?

Mr. REISCHAUER. It is a similar type of approach.

I might add that it might be regarded as quite inequitable to subject health premiums to the income tax when we have an unreformed system, simply because the level of premiums reflects a good deal more than the richness of the benefit package. It reflects how large the company is that you work for, since it costs a lot more for a small company to buy a certain health package than a

large company. It reflects what region of the country you live in. It reflects the risk pool that you are a part of. And certainly we would not want to be penalizing some Americans for the fact that they happen to have a plan that covers some individuals with quite expensive medical problems.

Mr. KLECZKA. So you are saying it would probably be more equitable to consider this after we establish not only health care reform but also a basic health insurance benefit and then possibly tax anything above and beyond?

Mr. REISCHAUER. Above, which is the approach that is reflected in the managed competition bill.

Mr. KLECZKA. Fine. Thank you, Doctor. Thank you, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Dr. Reischauer, just on normal practice reform for a moment. You seemed to kind of pooh-pooh the idea that medical malpractice reform would give us any savings and that those minimal savings may not be worth the lack of attention to obligations of the medical profession if they didn't have that threat hanging over them.

The recent study by the Lewin organization said that as much as \$76 billion might be saved over the next 5 years if medical malpractice reforms were enacted. Are you familiar with that study?

Mr. REISCHAUER. Yes, I am.

Mr. MCCRERY. That \$76 billion is a substantial amount of money in anybody's book. It wouldn't solve the problem but it would be a substantial savings, and, of course, they said it is hard to tell how much the savings could be. That is the top range.

The middle range, the Senate figure was \$35.81 billion, but still a substantial savings, and I don't think the malpractice reform model that they used is one which would completely remove the threat of some sort of retribution against physicians or hospitals that didn't perform their obligations properly.

Mr. REISCHAUER. I think you are reading a bit more into my comments than I intended.

Mr. MCCRERY. Good.

Mr. REISCHAUER. As I said, there are good reasons to go ahead with malpractice reform, but malpractice reform in and of itself is only going to make a small dent in this problem. The annual savings that were mentioned in that study for 1988 ranged from, I believe, about \$2 billion to maybe \$17 billion. We have health care spending running at something over \$800 billion a year and rising by roughly \$100 billion a year. So this would be like saving a few days' to a month's worth of increase in a certain year.

And that is certainly important. Many small steps might add up to a solution, but we should not kid ourselves that if we could produce substantial malpractice reform it would solve our overall problem.

Mr. ANDREWS. Would the gentleman yield for one quick question?

Mr. MCCRERY. Sure.

Mr. ANDREWS. Did the study deal with defensive medicine practice or just direct cost as a result of malpractice cases, litigations?

Mr. REISCHAUER. No, the study did deal with defensive medicine. That was the main component that it was getting at.

Mr. McCRERY. I just wanted to make sure, Dr. Reischauer, you were not suggesting that medical malpractice reform ought not be a part of any comprehensive approach to reforming the medical system.

Mr. REISCHAUER. No, I was not suggesting that.

Mr. McCRERY. Thank you.

You stated in your written testimony that unless the insured population is willing to accept less care, raising the level of care available to the uninsured will boost overall health costs.

I think that it is obvious to anybody who looks at it that if you expand the universe of people being served by the system, you are either going to increase costs substantially or you are going to reduce the level of health care that everybody else gets. And with that in mind, as we approach this debate and concern about health care, the health care system in toto, and particularly health care costs, would it not be useful for us at least to examine the possibility of first addressing the cost element in this equation without trying to address the access element at the same time?

Because, if we can address the cost element and get the rate of increase of cost down, say over the next 10 years, then it will be much easier to address the access problem when those costs are down; rather than trying to do it all at once and get everybody covered all at once and get costs down. It seems to me that is a battle that is going to be very, very difficult to win without substantially reducing the level of the quality of health care that most people currently insured are getting. Would you comment?

Mr. REISCHAUER. Yes. This is a judgment call for you to make. Most of the legislative proposals that you considered, at least last year, would not solve the access problem in its entirety. The managed competition approach that the Cooper bill embodied would cover roughly half of the uninsured, the Chairman's bill, the one this subcommittee reported out last year, would cover a smaller fraction of the uninsured. So there are ways of doing this that are halfway between addressing the access problem in its entirety and doing nothing about it.

Mr. McCRERY. So do you think it is useful to examine ways that just get at the cost first and not try to address the access?

Mr. REISCHAUER. I think any major health care reform is not going to occur with a big bang but is going to have to be phased in. We are talking about restructuring a very large and important segment of our economy, and it cannot be done overnight.

So I think what you are really talking about is which pieces to phase in first, and over what time period to phase in all of the pieces. This is a judgment call that certainly will be affected tremendously by the resources that you have available. By reducing costs, you obviously free up resources that could be used for other desirable objectives, such as covering the uninsured.

Mr. McCRERY. I will take that as a yes. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you very much. Thank you for being with us this morning, Mr. Reischauer.

I want to go back to your discussion of the CPI. Not to enlarge upon it, but starting from that point, because it is very significant that we don't look at total costs, and it is particularly significant when we talk about how we are going to look at the future and how we are going to evaluate the impact of our actions on the future.

One of the things that is really happening—and I hope you saw the Wall Street Journal article about what is happening in Minnesota, because networks of care look at the total costs. So they look at the cost of a technology in terms of the total cost of care, not just over that episode but that episode as a part of the larger episode of caring for someone over time. And I think that is one of the things we have to begin to look more carefully at as we estimate costs.

On page 7, you make the point that the problem is adversely affecting the quantity or quality of care received by consumers. Spending could be effectively controlled and the resources needed to address the access problem could be freed up without adversely affecting the quantity or quality.

Taking it a little out of context, but what I want to focus on is the issue of adverse effect on quantity and quality. We all know we have to affect quality and quantity; that there is overuse in the system, and that that actually has a negative quality impact and also an enormous cost impact. So the question is not how—the question is not opposing reductions in quantity, the question is how do we get at unneeded care versus needed care.

And, again, I would focus on networks as being in a far better position to make those kinds of judgments and as beginning to move far more aggressively.

You made the statement in answering a question that you are making a broad-based economic judgment on the economy as a whole. Well, when you look from the point of view of an economist, or any one of us out there, at the ability of an individual provider to cut costs, then you get into these issues of wages, and then you get into the issues of whether they can afford to buy the technology that could prevent or lower total costs.

But if we force everyone into networks, a network like a factory has a lot of options about controlling costs, far more options than the individual small provider or very small business. And that is why I think we have to take a different approach to evaluating the cost savings capability of a network as opposed to the current segregated, atomistic system of providers. Because now we have providers providing individual services; we don't have a system providing care.

In so many of your comments in your testimony about costs you are moving from today's reality, where care is provided by an individual provider at known costs: This is what labor costs me, this is what my rent costs me, this is what my utilities, this is what my malpractice costs. If you look at some of the hospitals that have gone to self-insuring, it is not the premium cost that is the big saving. That is not the big saving. What was the big saving was the reduction in incidents, translated into higher quality, but also the extraordinary savings associated with what care was delivered as

opposed to what care was not delivered. And you got that because the system began talking to itself.

When you have an atomistic system, physicians don't say what you are doing is dangerous. When he is sharing the responsibility and the consequences, then he says what you are doing is dangerous.

I can give you that example from hospitals, and I am sure you must have dealt with this, but that article in the Wall Street Journal begins to help us see how a network of care has the resources to look at costs over incident and over lifespan or some timeframe longer than individual episode of illness, and also the resources to be able to trade off a technological advance with the costs of care.

So I find in many of your discussions of cost drivers, your conclusion is based on the narrowness of the way that cost driver functions in our current network of care. But if you translate that into a different system of care, then we are going to have to really look at what are systems of care; what impact are systems of care having on costs as opposed to much looser networks.

And I think one of the things that plays into this is the study you did for me, the estimate you did for me, of if we assume everybody goes into sort of staff model HMOs, then you do get the same order of savings that we get from global budgets. And I think the committee should be conscious of that. You can save as much with everybody in the staff model HMOs as you can get with global budgeting without the adverse impacts.

But now if you look at what is happening in Minnesota, that is more flexible and may be a more powerful cost control tool than a narrowly based, again, far more narrowly based individual staff model HMO.

So rather than an individual question, when there are so many aspects of your testimony that actually partake in this same larger estimating issue, I wanted to put some of your comments in the context of a view that I think, furthermore, can be validated by our experience in other sectors of the economy; whereas the validation we are going to receive from price controls is very negative in terms of quality in the future as well as ultimately impact.

If you drive prices down too low, you end up driving the service out of the market and certainly affecting access and quality. And if you look at total quality management and what it has produced in terms of greater productivity and quality in other sectors, there is some hope there for both cost control and improved quality by doing the very thing we know we need to do, and that is eliminating unnecessary actions in the care delivery system, both in terms of tests but also in terms of referrals and that deep level of systemic change that really, alone, can address costs, either administrative or any other kind.

I used up all my time, but if the chairman wants to acknowledge you in a comment.

Mr. REISCHAUER. I want just a fraction of time to comment on what you have said.

I wouldn't disagree with the thrust of your comments, but I would point out that the section you quoted dealt with prices, not costs, and, effectively, I was reinforcing a point that Mr. Thomas made in his opening statement. What I was saying is, people look

out there and they see these huge increases in the medical care component of the CPI and they say, "Is price gouging going on? This sector is totally out of control; providers are charging anything they want."

I am saying that the way we measure prices, not costs, is deficient. There is a lot of quality improvement in the price measure; if we clamped on rigid price controls, we would not simply be squeezing out excess profit or egregious behavior by providers, we would be affecting the quality of services that we have available to us, and we should be very much aware of that. That is a very different discussion than looking at costs. Costs involve both prices and quantity.

I was out in Minnesota just a few weeks ago with Senator Durenberger looking at precisely the issues that were raised in that Wall Street Journal article.

Mrs. JOHNSON. Excellent. Thank you very much.

Chairman STARK. Dr. Brewster.

Mr. BREWSTER. Thank you, Mr. Chairman.

It was interesting listening to my colleague from California talk about redistribution of wealth a moment ago. As a provider, I have had many opportunities to see families through the years, who had one family member get very sick and their entire savings was spent on health care when the family had no health care coverage, and that is certainly a redistribution of wealth as well.

A comment you made that the savings in the single-payer was probably only \$30 or \$35 billion as opposed to \$75 or \$80 billion that many of us have been told, and I was curious where you determined those numbers.

Mr. REISCHAUER. We have done a number of reports and are updating our latest one that provides the detail of how we do these estimates and compares them with other ones that are available.

Mr. BREWSTER. Whenever you get those figures together, we would like to see what you finally did there.

[The information follows:]

CBO's estimates will change somewhat as a result of refinements still to be made, but preliminary estimates of savings on overhead under single-payer systems are described below for two distinct cases. In both cases, the results assume that a single-payer system with universal coverage had been in place throughout 1991.

Single-payer system with copayment requirements and hospitals' current management information and case-specific billing systems. In this case, savings on overhead expenses would be about \$34 billion. Of that amount, savings on insurance overhead would be about \$23 billion, while savings of another \$11 billion would accrue to providers. This estimate assumes that insurance overhead costs as a percentage of personal health expenditures would drop by 3.6 percent. It assumes that hospitals' overhead would fall by 1.6 percent and that physicians' overhead would be 4.1 percent lower, as a percentage of their revenues.

Canadian-style single-payer system with no copayment requirements and global budgeting for hospitals. Savings on overhead expenses in this case would be about \$53 billion. Of that amount, savings on insurance overhead would be about \$26 billion, while another \$27 billion in savings would accrue to providers. This estimate assumes that insurance overhead costs as a percentage of personal health expenditures would drop by 4.2 percent. It also assumes that hospitals' overhead would fall by 6 percent and that physicians' overhead would drop by 6.2 percent, as a percentage of their revenues.

Only the latter estimate (for the Canadian-style single payer) is comparable with other recent estimates of savings on overhead, which ranged from \$47 billion to \$67 billion for 1991.

Mr. BREWSTER. Another point. It is my opinion we have far greater utilization, in fact overutilization, by a greater number of our people than probably anywhere else in the world. I think a lot of that has to do with the fact many of our companies provide first dollar coverage. Maybe when they were doing well a few years ago that was negotiated to have first dollar coverage.

Do you do any studies to determine the relationship between first dollar coverage and overutilization as opposed to a copayer deductible with overutilization?

Mr. REISCHAUER. The Rand Corp. has done a number of studies in that area, but you find, actually, that Americans don't stack up badly in international comparisons. There are many countries that have greater numbers of doctor visits per inhabitant than the United States does.

It is also true that while we have high incidences of certain kinds of surgical and hospital procedures—bypass operations, cataract surgery, and so on—average lengths of stay in American hospitals are considerably below those of most of the countries that provide national health insurance of some kind.

Mr. BREWSTER. Is it also true some of those countries who have a high percentage of doctor visits, higher than ours, such as Canada, have no copay?

Mr. REISCHAUER. Correct.

Mr. BREWSTER. But there has been no study to determine if copays maybe cut back on utilization?

Mr. REISCHAUER. Yes, there has. I don't have the numbers at my fingertips, but the Rand Corp. did an evaluation of what was called the national health insurance experiment, in which it varied co-payments and deductibles and estimated the impact that this had on the number of doctor visits and other procedures.

In summary, what these studies show is that when you increase deductibles or coinsurance, it reduces the number of initial visits to the medical profession, but once someone is in the hands of a doctor, it has very little impact on the number of procedures or the costs after that point. We, as consumers, feel ourselves incapable of making these decisions and delegate them to the provider and the provider often is unaware of exactly what kind of insurance coverage we have, and in any case the provider is most interested in providing the best care that he or she knows how to provide.

Mr. BREWSTER. Is there any other country in your study that you know that goes to such heroic measures as we do in truly terminal conditions, life support systems, et cetera, for maybe an extra week of life for a 90-year-old? Is that only common to the United States or is that common in other countries as well?

Mr. REISCHAUER. No, I think it is taken to its extreme in the United States, but that is because a lot of this involves extremely high-tech medicine with a tremendous capital component to it, and we have the highest technology medicine of any country in the world.

Mr. BREWSTER. Is there any relationship there to the liability question?

Mr. REISCHAUER. I don't know the answer to that. I check on it and give it to you for the record.

[The information follows:]

To the best of my knowledge, studies that address the specific issue of whether older Americans receive more intensive medical care because of providers' concerns about professional liability are, in general, not available.

One exception, however, is a study by Henry J. Aaron and William B. Schwartz ["The Painful Prescription: Rationing Hospital Care" (Washington, D.C.: The Brookings Institution, 1984)]. Aaron and Schwartz examined how budgetary limits had affected the allocation of resources in British hospitals and how these allocation processes differed from those observed in the United States. They reported that, in Britain, age functioned as an implicit rationing criterion limiting access by older people to some health care services (for example, dialysis) and that the lower frequency of malpractice suits—partly reflecting greater financial barriers to bringing them—had been one factor that allowed this situation to continue.

Mr. BREWSTER. Thank you for a very good presentation.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Dr. Reischauer, there are terms that are becoming more and more popularly used; of course, managed competition is one of them; global budget is another one. What is the primary value of a global budget, if it is used as a tool in this context?

Mr. REISCHAUER. A global budget is a device that is used to hold down total health care expenditures, or expenditures for an institu-

tion to which it is applied. If you mean global budgets for hospitals, a hospital is given a fixed amount of resources and told that it has to provide services for the upcoming period within that budget constraint.

Mr. THOMAS. Isn't it somewhat a conflict of terms to talk about a global budget over hospitals or a global budget over providers?

Mr. REISCHAUER. Well, a global budget for hospitals simply means it covers all of the services provided by that hospital.

Mr. THOMAS. I understand that. Isn't the direction we are looking at a global budget over all health care costs; a truly global budget? What is the primary advantage of looking at—is it fair to call a global budget a fairly rigid cost control mechanism?

Mr. REISCHAUER. Well, in theory it can be rigid; in practice it might be less rigid.

Mr. THOMAS. Then, it really isn't a global budget, is it?

Mr. REISCHAUER. It might be difficult to enforce. I mean it would involve—

Mr. THOMAS. What is the advantage of using them?

Mr. REISCHAUER. The advantage is that in other countries they have been used effectively to hold down the growth of health care expenditures.

Mr. THOMAS. At what cost?

Mr. REISCHAUER. At considerable cost in terms of the amount of freedom that the consumer has—

Mr. THOMAS. On page 7, you indicate that cost controls are likely to put some real limits on, you have quality or quantity of medical care that is available.

Isn't this a kind of a stylistic use? Because whenever you reduce quality, to a very great extent you reduce quantity. Quantity and quality are kind of intermixed, and the sure result of global budgets will be a reduction of quality and quantity, if, in fact, they are enforced.

But don't you save money, quote-unquote, under the Federal budget rules more effectively than almost any other way if you go to global budgets?

Mr. REISCHAUER. Well, it depends very much on how the global budgets are specified, as we discussed at our last hearing in which I was talking about these issues. Specifying a global budget at the national level in and of itself is not likely to save much money unless there is a procedure for translating that global budget into budgets for the regional levels, the hospital level, the doctor's office level. There are various mechanisms for doing this, all of which restrict the freedom that providers now have.

Mr. THOMAS. But if you can create a paper model that says it does that under our budget scoring procedure, you can save a lot of money, vis-a-vis some fundamental real reforms, because, after all, are we not talking about trying to change behavior both of the providers and of the consumers?

Let me underscore a comment that my colleague from Louisiana made, because although the dollar amount may not be significant in the malpractice or defensive medicine area, and somehow for the life of me I can't get away from the fact that somewhere between 20 and 70 is not a big number. I mean, it is to me, but you are right when you look at an \$800 billion problem.

Mr. REISCHAUER. Those are savings over a 5-year period. So divide them by 5 before you make the comparison with the \$840 billion.

Mr. THOMAS. I understand. But more importantly, one of the arguments made again and again by providers is they have to practice defensive medicine. There is a perception on their part that this is a major cost. Just as when you look at all the polls in terms of the recipients, they don't believe that someone else is paying the major portion of the health care cost; they believe they are.

We have got a lot of perception and behavioral changes to make. It seems to me we need to weigh the components of any changed system for its educational value, if you will, as well as the actual dollar costs.

I have sometimes found in dealing with my adolescent children, who are now in their early twenties, that one of the ways that you can get them into a funnel of choice is to create a situation in which you have taken away from them the easy arguments that are the easy out or copout and force them to look at the real choices.

I think over the next several years our biggest fundamental problem is going to be to get both providers and consumers to look at the real story instead of the perceived story. And if we can make some changes along the way that take away the easy excuses, although in a dollars-and-cents fashion it may not have a major impact, I believe in changed behavior, which is ultimately the only way we will solve this problem, there may be some major positives in them.

And let me say, Mr. Chairman, I am leaving now not because I don't want to stay but because President Clinton has asked us to convene to discuss a number of issues and I am sure this is going to be one of them.

Chairman STARK. Please give him my regards.

Bob, thank you. We appreciate your testimony, and as I said, I think we will be seeing a lot more of each other during the course of this year as we begin to not only continue to discuss options in health reform but as we begin to put forth precise price tags on the various options. I look forward to continue to work with you.

We will continue this morning with representatives from the industrial community, we have three witnesses, a gentleman familiar to most of the panel members, Walter Maher, director of Federal relations for the Chrysler Corp.; August Lauer, the senior manager for employee benefits with Federal Express; and Alan Peres, manager of benefit planning for the Ameritech Corp., who is accompanied by Sharon Canner, who is assistant vice president for industrial relations at the National Association of Manufacturers.

I would remind the panelists that, without objection, their prepared statements will appear in the record. Each of you may summarize your prepared testimony or expand on it to enlighten the committee.

Wally, why don't you lead off.

STATEMENT OF WALTER B. MAHER, DIRECTOR OF FEDERAL
RELATIONS, CHRYSLER CORP.

Mr. MAHER. Thank you, Mr. Chairman.

I appreciate the opportunity to be here. Not only from the discussion that we have heard this morning, but the evidence I think is getting insurmountable that the unrelenting increase in U.S. health costs make it very clear our country cannot afford to continue to finance health care in the haphazard way we do today.

The sheer magnitude of health costs has caused all of the various players to do their best to moderate their own health spending by trying to shift costs to other players and there has been no focus on overall cost control. This cost shifting has added substantially to the health cost burden of those employers who have continued to provide health coverage for employees and retirees.

According to a recent study by the National Association of Manufacturers, represented here today, 28 percent of manufacturer's health costs in this country have been represented by cost shifted by others. Accordingly, my company believes fundamental changes in the way health care is financed are required.

However, we would caution that in developing a health reform strategy, we have to recognize that our country's health policy has got to be consistent with our country's economic policy and both have to be consistent with our expectations for Americans' standard of living.

For example, if it is our expectation that all Americans are going to have access to affordable health care, and if it is our expectation that American businesses are going to be expected to compete successfully in a global economy and remain a source of high value added jobs in this country, and if it is our expectation that Americans are going to continue to be able to improve their standard of living, we have to understand all of those goals are interrelated and we cannot accomplish any of them unless we accomplish all of them.

Now, another thing we have to understand, particularly in view of Dr. Reischauer's comments, is the gap, the magnitude of the gap between what we spend in this country and what other nations spend. We spend 45 percent more per capita than the second most expensive country on earth, which happens to be Canada, and more troubling to my industry is that we spend 73 percent more than Germany and 119 percent more per capita than Japan.

That disadvantage does not go away when foreign firms locate operations in the United States, because they employ much younger workers, 13 years younger on average in the case of the Japanese transplants, and have virtually no retirees, and this translates into a real cost disadvantage. The irony is if we were to build factories in their country, we would not get a similar advantage, because we would pay the same payroll tax that they do.

The University of Michigan recently analyzed this and they found a staggering competitive disadvantage, over \$500 per car disadvantage compared with the Japanese and over \$600 per car disadvantage compared with the transplants. And disadvantages of this magnitude are not sustainable because the fact of life is that while we have to build our cars incurring U.S. level health care

costs, we have to price our cars to meet global competitors who are not burdened by those costs. As a result, our margins and our profits and our ability to invest in our business suffers.

With respect to the comments Dr. Reischauer made, it does very little to the overall well-being of this country if all U.S. business does to compensate for this is to gradually lower and lower and lower the wages of American citizens. Because what is the end result of that? You have an American citizenry with no disposable income. They may have a hell of a great health benefit plan but they have no disposable income. That is not good for any business. And any business that wishes to succeed internationally has to be strong domestically, and you are not going to be strong domestically if your citizens have all their disposable income absorbed by the health care system.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT OF WALTHER B. MAHER, DIRECTOR, FEDERAL RELATIONS, CHRYSLER CORPORATION

BACKGROUND

The rising cost of health care and the growing number of Americans without health insurance coverage have focused attention on the flaws in the ways health care is financed and delivered in this country. It has become quite clear that relying on voluntary employer programs and targeted government programs like Medicaid and Medicare is capable of neither providing coverage to all Americans or assuring costs are controlled. To the contrary, it contributes to gaps in coverage, cost shifting among the various payers, and the spiralling costs that are making health care less and less affordable.

Moreover, the cost of the current system penalizes American businesses competing in a global economy, and thus has proven harmful to the creation of good paying manufacturing jobs in this country. It further penalizes mature American firms with older workers and generations of retirees who must compete with newly established subsidiaries of foreign owned firms located in America.

Finally, the current system is steadily absorbing the wealth of this country, is eroding the standard of living of the average American, and is stifling broad based economic growth.

In short, if America is to solve its budget crisis, meet the health care needs of all citizens, and restore and improve both the standard of living of its people and the competitiveness of its businesses, substantive health system reform, addressing all of the above critical issues, must become a reality.

CAUSE OF PROBLEM - THE HEALTH POLICY VOID

The United States has depended on a patchwork quilt of public and employer plans, all struggling to meet the health care needs of various sub-groups of our country's population. However, the unrelenting increase in U.S. health costs brought about by our health policy void, coupled with the realities of the new global economy, has made it vividly clear our country can no longer afford to finance health care in the haphazard way it does today. The sheer magnitude of health costs has literally ripped apart our patchwork quilt. It has caused all of the various players to do their best to moderate their own health spending, often by shifting costs to other players. There has been no focus on overall cost control. Many have found the easiest way to cut their costs has been to simply not offer health benefits. Government, for example, has done that by covering only 4 in 10 poor under Medicaid. In addition, government has further controlled its Medicaid outlays by undercompensating doctors and hospitals. Employers are also curtailing benefits, or dropping them altogether, or not offering them in the first place.

All this cost shifting has added substantially to the health cost burden of those employers who continue to provide health coverage for employees and retirees. According to a recent study by the National Association of Manufacturers, fully 28% of U.S. manufacturer's health costs were the result of such cost shifting. Accordingly, Chrysler Corporation believes fundamental changes in the way health care is financed and delivered will be required if we are to control health spending, guarantee universal coverage, improve the quality of patient care, and maintain high value jobs and a manufacturing base in this country.

In developing our health reform strategy, however, we must recognize that our country's health policy must be consistent with our country's economic policy, and both must be consistent with our expectations for Americans' standard of living.

For example, if it is our expectation that:

- All Americans will have access to affordable health care, and
- American business will be expected to compete successfully in a global economy and remain a source of high value jobs for American citizens, and
- Americans will be able to improve their standard of living,

we must understand that all of these goals are interrelated. We can accomplish none unless we accomplish them all.

We should no longer focus on isolated issues. We must not require business to choose between shifting costs to retirees, shifting them to employees, or becoming a gradually weaker competitor and eventually failing. Instead, we need to focus on (1) assuring a system is in place which guarantees all Americans access to affordable health care, (2) assuring a process is in place to control health spending, and keep such spending commensurate with the nation's ability to pay for it and all of our other societal needs, and (3) assuring the health system is financed equitably, neither harming the financial security of families nor the economic viability of businesses, including businesses confronting global competition.

MAGNITUDE OF COST PROBLEM

The most current Department of Commerce report on health costs is truly alarming. Health spending will approach \$1 trillion this year, 15% of our GDP. Worse yet, Commerce forecasts that without a major overhaul of the health system, costs will increase 12-15% per year for the next 5 years.

Using the **LOW** estimate, this means health spending will exceed \$2 trillion in the year 2000, and consume over 20% of our GDP.

Further, the gap between what we spend compared with other nations is huge. We spend 45% more, per capita, than the second most expensive country, Canada. More troubling to my industry is the fact we spend 73% more than Germany, and 119% more than Japan.

It is not just the raw dollars, however, that are a problem. The sharp differences in international health costs pose major competitive problems for our country and our industry. Not only do foreign producers enjoy lower costs, but health costs are spread much more broadly in foreign countries.

For example, whether it be Germany, Japan, France or Italy, all employers help finance health care for employees through payroll taxes.

And the competitive disadvantage does not disappear when foreign firms locate operations in our country. They employ much younger work forces ... 13 years younger in the case of the Japanese Transplants ... and have virtually no retirees! This translates into a real cost advantage. The irony is, were we to build factories in their countries, we would **not** get a similar advantage. Why? Because we would pay the same payroll tax they do.

The University of Michigan recently analyzed all of this. What they found was a staggering competitive disadvantage:

- ▶ Over \$500 per car compared with the Japanese;
- ▶ Over \$600 per car compared with the Transplants.

Competitive disadvantages of this magnitude are clearly not sustainable. Change is essential. For us, the facts of life are that, while we must build our cars incurring U.S. level health care input costs, we must **price** our products to meet our **global** competitors who are **not** burdened with such costs. As a result, our margins and our profits and our ability to invest in our business suffers.

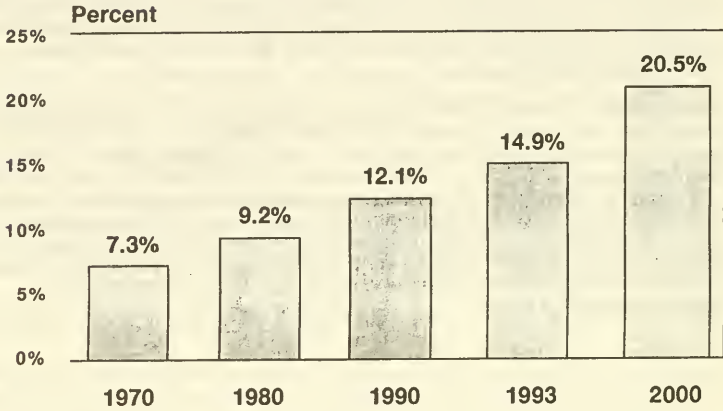
We are convinced that our country will not solve its health cost problem until it addresses the health system as a whole. The public and private sectors must work together on this problem, just like joint venture partners. The divide and conquer days of cost shifting must stop.

CONCLUSION

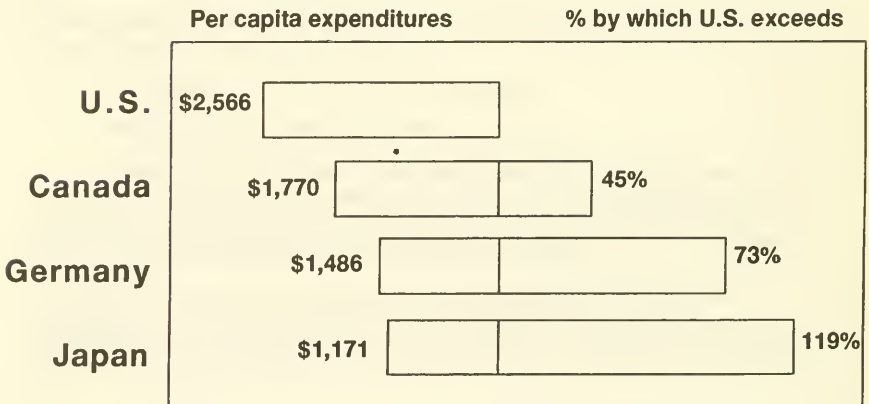
Americans are clearly not yet fully aware of the growing costs they continue to bear as a result of the failure to step up to the need to reform our nation's health care system. Health costs are growing far faster than family income, than business income, than local, state or federal government income (i.e., tax receipts). The result: a steady reduction in citizens' standard of living as health care absorbs more and more of our citizens' and our nation's resources and saps the strength of its businesses. Indeed, as health spending remains unchecked, spending for all other societal needs is effectively being rationed.

The businesses of America, particularly our manufacturing base, need health system reform now. The citizens of America need health system reform now to help them regain the standard of living they have seen erode over the past decade. We need to take the hundreds of billions of dollars our health system wastes each year and make it available for redeployment in our economy, investing to educate children, to enhance the skills of our workers, to improve our infrastructure, and to make our domestic industries more efficient. In short, to help meet the needs of all citizens and our economy in general. We must bring our country's health costs much more in line with our major trading partners or continue to pay the price of a loss of jobs and a declining standard of living.

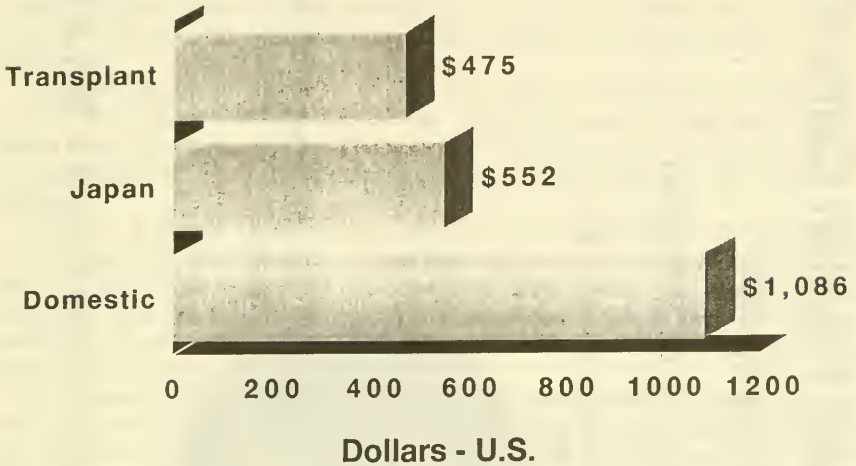
Health Expenditures as a Percent of GNP 1970 - 2000



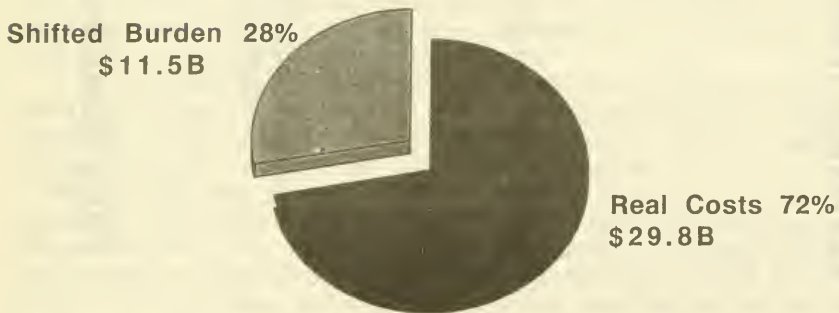
Per Capita Health Spending in Selected Countries, 1990



Total Health Care Cost Per Vehicle - 1990



Health Care Costs Manufacturing Sector (\$ Billions)



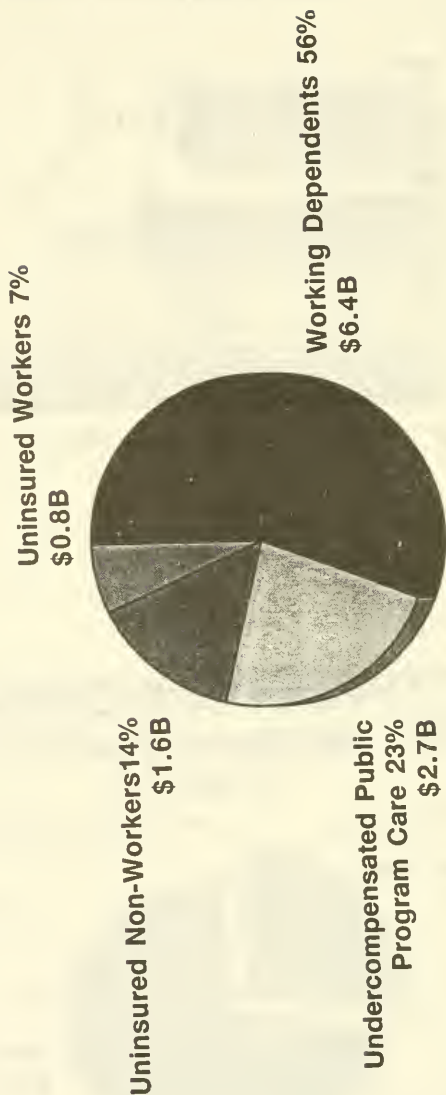
Impact of Cost Shifting

Total Manufacturing Sector
Health Costs = \$41.3 Billion

Components of Shifted Health Care Costs

Manufacturing Sector

Total Cost Shifted = \$11.5 Billion



Total Manufacturing Sector Health Care Costs = \$41.3 Billion

Chairman STARK. Mr. Lauer.

STATEMENT OF AUGUST LAUER, SENIOR MANAGER, EMPLOYEE BENEFITS, FEDERAL EXPRESS CORP.

Mr. LAUER. Good morning.

Chairman STARK. Good morning.

Mr. LAUER. I would like to thank you for this opportunity to testify and to express our views on the impact of rising health care costs.

Federal Express employs 94,000 employees worldwide; 80,000 of those employees are located in the United States where each and every one of them, part time and full time, are provided with a comprehensive and competitive benefits package at no cost to them.

Federal Express is a young company, 20 years old, with a relatively young, healthy work force. Our average employee age is 35, and we have less than 500 retirees who are eligible for health care benefits. The largest portion of our health care costs are related to maternity expenses, reflecting the types of health problems associated with a youthful work force.

At Federal Express, we view an employee's benefits package as just one part of the employee's total compensation package. When we examine the expenses incurred for this total package, we find that Federal Express spends approximately 50 percent of its annual operating expenses on providing salaries and benefits to our employees. In other words, for every dollar we pay our employees in salary, we pay another 30 to 35 cents in benefits.

That means each year we have to deliver over 2,500 packages per employee to provide compensation and benefits for our work force. By most corporate standards, this is a high percentage of operating expenses. However, at Federal Express we think it is just the cost of doing business. We were founded on the general philosophy of treating people well. This philosophy, people, service, profits—PSP—is the cornerstone of our organization and essentially means that by taking care of our people, they will, in turn, deliver the impeccable service demanded by our customers who will reward us with the profitability to secure our future.

It is this philosophy that has enabled Federal Express to grow from \$1 billion in revenue in 1983 to approximately \$8 billion today. An achievement such as this could only have been accomplished through satisfied and dedicated employees.

Federal Express prides itself on being an innovative leader in personnel programs and practices. Our leadership has not gone unrecognized. In 1990, we became the first service company to win the prestigious Malcolm Baldrige National Quality Award. None of this could have been achieved without our people-first philosophy, however, employee satisfaction does not come without a price.

One of the essential elements of our PSP philosophy is to provide our employees with a comprehensive benefits package. As a company dedicated to its employees, we want to be able to continue this benefit: however, with the ever increasing cost of health cost, this is becoming more and more difficult.

Nationally, health care costs are spiraling out of control and have become the fastest growing component of our gross domestic product, and Federal Express is feeling that impact. As you can see in attachment A, our health care costs continue to rise while our pretax profits are declining.

In 1987, our total health care costs were \$64 million. Today, that number has increased to \$215 million. That is an increase of 236 percent in 6 years. When broken down further, you will find our total health care costs per employee increased 90 percent from 1987 to 1992, rising from \$1,612 per employee to \$3,074.

Since our founding in 1973, Federal Express has provided health care coverage to all our employees at no cost to them. However, we have asked our employees to share on a 50-50 basis the cost of providing health care benefits to their dependents. As health care costs have risen, Federal Express has assumed a greater portion of the cost for dependent coverage as the impact would have meant significant cost increases for our employees.

In 1992, Federal Express' share providing dependent coverage was 80 percent, with the employee paying only 20 percent. This is a substantial departure from our original 50-50 philosophy. However, there is a limit to how much Federal Express can insulate its employees in rising health care costs without influencing pay increases or without adversely affecting either our customers through higher prices or our shareholders through lower earnings.

The net impact, as shown in attachment B, is that the company's share of per employee cost increased 96 percent, from \$1,320 per employee to \$2,589 during this same time period. This equates to an increase of 15 percent per year. This type of increase is unacceptable to us.

The impact of rising health care costs of Federal Express has been tremendous. However, compared to other Fortune 500 companies, we have been able to impact our costs because of our existing demographics and our efforts to implement cost-effective programs in lieu of reducing health care benefits.

However impressive our voluntary efforts have been to control costs and provide quality care, we have not been able to sufficiently reduce health care costs. This impacts our ability to increase resources to other aspects of our total compensation package.

Too many of the factors contributing to the increase in our health care costs are outside our control. Cost shifting from lack of coverage and lower provider reimbursement rates in Government-sponsored health care programs are simply not issues we can address on our own. We need your help in controlling these costs.

We are absolutely committed to the need for national health system reform. We are working through several coalitions and associations such as the Washington Business Group on Health, the Association of Private Pension and Welfare Plans, and the Society for Human Resource Management to determine appropriate alternatives for such reforms.

Through national reform, we anticipate an economic stimulus that will lead to greater security for our employees and our shareholders. We applaud your efforts in examining our health care system and pledge our support in doing our share to affect reform.

We thank you for this opportunity to speak with you today.

[The prepared statement follows:]

STATEMENT OF AUGUST LAUER, SENIOR MANAGER, EMPLOYEE BENEFITS, FEDERAL EXPRESS CORPORATION

Mr. Chairman, and members of the Sub-Committee, my name is Gus Lauer. I am the Senior Manager of Employee Benefits for Federal Express Corporation. I would like to thank you for this opportunity to testify and express our views on the impact of rising health care costs.

Federal Express was founded in 1973, as an express air cargo service. Since that time, the company has expanded its services to offer the finest delivery of documents, packages and freight "absolutely, positively" on time, worldwide.

Federal Express employs 94,000 employees worldwide. 80,000 of those employees are located in the United States where each and every one of them, part-time and full-time, are provided with a comprehensive and competitive benefits package at no cost to them.

Federal Express is a young company (20 years old) with a relatively young, healthy workforce. Our average employee age is 35. And we have less than 500 retirees who are eligible for health care benefits. The largest portion of our health care costs are related to maternity expenses, reflecting the types of health problems associated with a youthful workforce.

At Federal Express, we view an employee's benefits package as just one part of the employees' "total compensation package". When we examine the expenses incurred for this "total" package, we find that Federal Express spends approximately 50% of its annual operating expenses on providing salaries and benefits to our employees. In other words, for every dollar we pay our employees in salary, we pay another 30 to 35 cents in benefits. That means, each year we have to deliver over 2,500 packages per employee to provide compensation and benefits for our workforce.

By most corporate standards, this is a high percentage of operating expenses; however, at Federal Express we think its just the cost of doing business. We were founded on a general philosophy of treating people well. This philosophy, PEOPLE-SERVICE-PROFIT (PSP), is the cornerstone of our organization and essentially means, that by taking care of our people, they will in turn, deliver the impeccable service demanded by our customers who will reward us with the profitability to secure our future.

It is this philosophy that has enabled Federal Express to grow from \$1 billion in revenue in 1983 to approximately \$8 billion today. An achievement such as this, could only have been accomplished through satisfied and dedicated employees.

Federal Express prides itself on being an innovative leader in personnel programs and practices. And our leadership has not gone unrecognized. Recently (January, 1993) we were rated as one of the Ten Best Companies to Work for in America. This is the second time we have received this recognition as well as numerous other awards. In 1990, we became the first service company to win the prestigious Malcolm Baldrige National Quality Award. None of this could have been achieved without our PEOPLE FIRST philosophy.

However, employee satisfaction doesn't come without a price.

One of the essential elements of our PSP philosophy is to provide our employees with a comprehensive benefits package. As a company dedicated to its employees, we want to be able to continue this benefit; however, with the ever increasing costs of health care, this is becoming more and more difficult.

Nationally, health care costs are spiraling out of control and have become the fastest growing component of our Gross Domestic Product. And Federal Express is feeling that impact. As you can see from the following chart, our health care costs continue to rise while our pre-tax profits are declining. (See Attachment A)

In 1987, our total health care costs were \$64 million dollars. Today that number has increased to \$215 million. That's an increase of 236% in six years.

When broken down further, you will find that our total health care costs **per employee** increased 90% from 1987 to 1992, rising from \$1,612 per employee to \$3,074.

Since our founding in 1973, Federal Express has provided health care coverage to our employees at no cost to them. However, we have asked our employees to share, on a 50/50 basis, the cost of providing health care benefits to their dependents. As health care costs have risen, Federal Express has assumed a greater portion of the costs for dependent coverage, as the impact would have meant significant costs increases for our employees. In 1992, Federal Express' share of providing dependent coverage was 80% with the employee paying only 20%. This is a substantial departure from our original 50/50 philosophy.

The net impact is that the company's share of "per employee cost" increased 96% (from \$1320 per employee to \$2,589) during this same time period. (See Attachment B) This equates to an increase of 15% per year. This type of increase is unacceptable to Federal Express.

The impact of rising health care costs to Federal Express has been tremendous; however, compared to other Fortune 500 companies, we have been able to impact our costs because of our existing demographics and our efforts to implement cost effective programs.

In an effort to expand benefits and the services available to our employees, we have implemented roughly 60 HMOs across the nation. At our headquarters in Memphis, Tennessee, we offer our employees an option to participate in a Preferred Provider Organization. This allows the employees who choose to participate in the program a greater benefit than those who choose not to participate. In 1985, Federal Express joined forces with other local businesses in Memphis to address the rising costs and the quality of health care. Through the formation of the Memphis Business Group on Health, we have been able to do a better job not only of controlling the costs of care in Memphis, but in providing the quality of care that we demand for our employees. Due to the fact that we have employees in all 50 states, we are not able to realize these benefits for our entire workforce.

The Memphis Business Group on Health is currently one of only two groups in the United States actively working on a community health management information system (CHMIS) which will give the community access to health care quality data that is needed in order to make the appropriate decisions as to the best and most efficient health care providers. This program, created through a grant from the Hartford Foundation, will assist us in meeting the coalition's objectives and is a unique cooperative effort between all local "players" in the health care system.

As another of our efforts to control costs, we implemented a psychiatric/substance abuse network nationwide, which helped us see a 25% decline in psychiatric costs over the last 3 years. By controlling access to the system, we have been able to increase our benefits while at the same time reduce costs through negotiated rates. This is also true of our managed care programs.

Most recently, we offered our employees in California a chance to participate in a managed care network. The use of these networks will expand in the near future, but unfortunately, about 25% of our employee base will not be able to participate in these networks due to geographic restrictions.

However impressive our voluntary efforts have been to control costs and provide quality care, we have not been able to sufficiently reduce health care costs. This impacts our ability to increase resources to other aspects of our total compensation package.

Too many of the factors contributing to the increase in our health care costs are outside of our control. Cost shifting from lack of coverage and lower provider reimbursement rates in government-sponsored health care programs are simply not issues that we can address on our own. We need **your** help in controlling these costs.

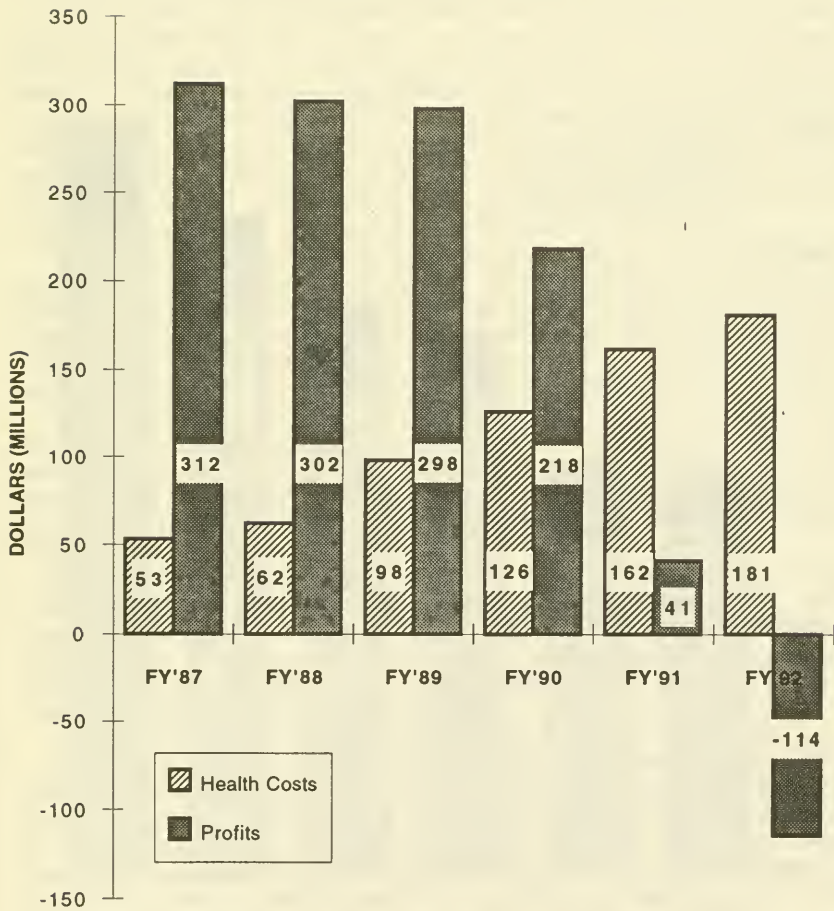
We are absolutely committed to the need for national health system reform. We are working through several coalitions and associations such as, the Washington Business Group on Health, the Association of Private Pension and Welfare Plans, and the Society for Human Resource Management to determine appropriate alternatives for such reforms. Through national reform, we anticipate an economic stimulus that will lead to greater security for our employees and our shareholders.

We applaud your efforts in examining our health care system and pledge our support in doing our share to affect reform.

We thank you for the opportunity to speak with you today.

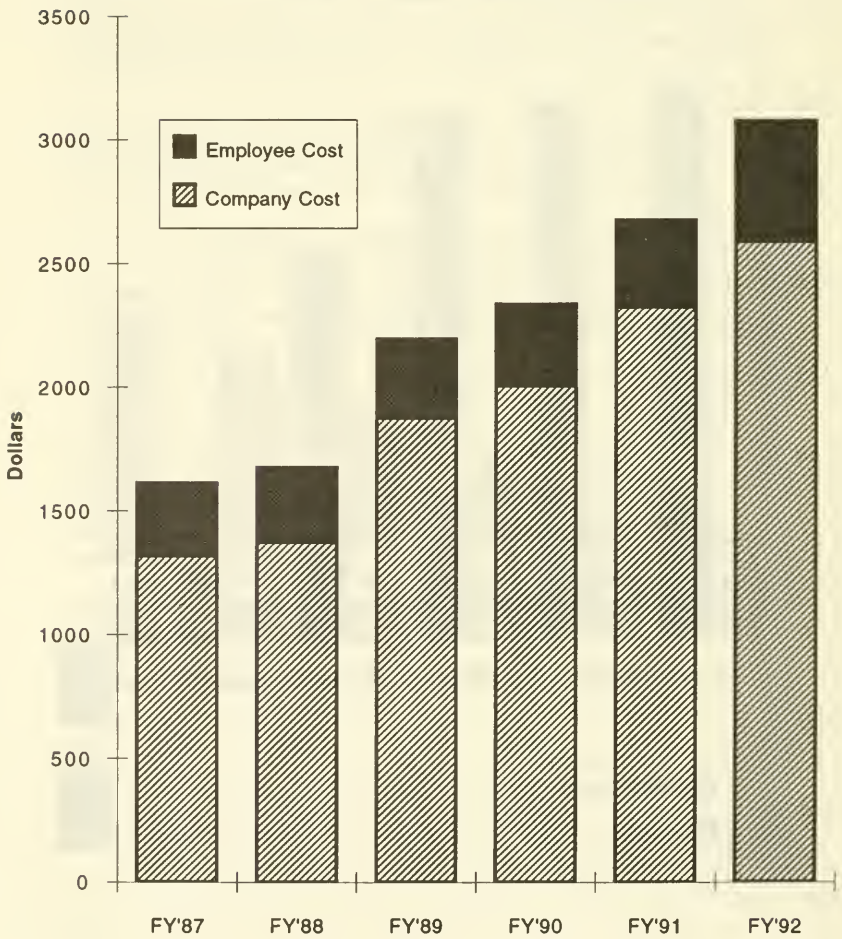
ATTACHMENT A

NET HEALTH CARE COSTS vs. PRE-TAX PROFITS



ATTACHMENT B

TOTAL HEALTH CARE COST PER EMPLOYEE
EMPLOYEE & COMPANY SHARES



Chairman STARK. Thank you.
Mr. Peres.

STATEMENT OF ALAN PERES, MANAGER, BENEFITS PLANNING, AMERITECH CORP., CHICAGO, ILL., ON BEHALF TO THE NATIONAL ASSOCIATION OF MANUFACTURERS (NAM), ACCOMPANIED BY SHARON CANNER, ASSISTANT VICE PRESIDENT, INDUSTRIAL RELATIONS, NAM

Mr. PERES. Thank you, Mr. Chairman. I am Alan Peres, manager of benefits planning with Ameritech.

Ameritech is a telecommunications and information services company headquartered in Chicago. The cost of providing coverage to Ameritech's active and retired employees in 1991 exceeded \$410 million.

I am pleased to appear here today on behalf of the National Association of Manufacturers' 12,000 member companies, over two-thirds of which have fewer than 500 employees.

In February, the National Association of Manufacturers' board passed a resolution to change our response to reform proposals. The board asked that staff and the health care subcommittee, which I chair, look at packages in their entirety rather than looking at specific elements; that is, to look at whether that package will have a positive effect rather than reacting to particular elements that in the past we may have opposed; and also to particularly look at the long-term effects of the changes, because that is the most important timeframe to look at.

The resolution was based, in part, on a survey of NAM members conducted last summer. The survey really looked at all of the membership, from the smallest companies to the largest, all geographic areas, various industrial sectors. It showed that the companies' health care costs were rising 15 percent yearly. This amounted to approximately 31 percent of corporate net profits in 1991.

The most frequently cited reason by the respondents for rising health care costs was malpractice. Beyond the actual cost of malpractice, in terms of suits and insurance, we believe the related practice of defensive medicine is the real villain. A recent study concludes that \$38 billion could be saved over 5 years if medical liability tort reforms were enacted.

Perhaps more importantly, survey respondents showed a significant change in thinking about what system changes they would support. Tremendous cost increases, we believe, are responsible for this change. Over three-quarters of the respondents felt the system was in need of fundamental reform, but there was no clear agreement on what changes were necessary.

I would like to mention just a few of the survey responses.

Slightly over half of the respondents favored pay or play. Pay or play was a specific question that we asked because it happened to be a hot topic at the time we developed the survey. They supported it if combined with other elements of reform. It was much less in favor as a specific item. This is important because it reaffirms the need for systemic reform and not to pick one specific item. If you do pick one specific item, the level of opposition will be much greater.

One-third of the respondents supported national spending caps on health care, again within the context of overall reform. About a third supported limiting the tax-free nature of employee health benefits for the employee if revenues were used to expand coverage for the uninsured. Limiting the employer deduction was favored by only about a quarter of the respondents. Forty-two percent supported a system of binding negotiation involving both private and public payers as a means to eliminate cost shifting.

U.S. firms, many of which are responsible for workplace benefits, view with dismay the annual health care cost increases three times general inflation and higher. Health costs are having a major impact on manufacturers. While difficult to quantify, there is a growing belief that, as a result of increased spending on health care, less is being spent on upgrading plant and facilities, research and development, training, retraining, and other critical business investment issues.

Rising health costs may affect employers in different ways. For example, some firms may choose to pay more overtime rather than hire new workers because of the potential health benefit costs. This reluctance to hire may contribute to higher unemployment rates.

Many companies in America, and Ameritech is one of them, have aggressively initiated various cost containment strategies, restructured benefits plans, joined with other businesses and, in some cases, the provider to attack costs. We know in the long run we do need a national approach, one that addresses private sector plans, public sector plans, and all the uninsured to stop the cost shifts and the shifting of blame from one group to another.

Ultimately, we must fashion a health care system that reduces the high rate of cost increases for American business and preserves our future economic viability and capacity to support other essential national priorities.

Thank you.

[The prepared statement follows:]

Testimony of
 Alan Peres
 Manager, Benefits Planning
 Ameritech Corporation
 on Behalf of the
 National Association of Manufacturers
 on the Impact of Health Costs on Employers
 Before the Subcommittee on Health Care
 House Ways and Means Committee
 March 2, 1993

Mr. Chairman and members of the Ways and Means Health Subcommittee, I am Alan Peres, Manager of Benefits Planning, Ameritech Corporation. I am the Chairman of NAM's Health Care Policy Subcommittee and am a member of the Board of Directors of the Washington Business Group on Health. For sometime both groups have been working together on health care reform.

Ameritech is a telecommunications and information services company headquartered in Chicago. Ameritech has 70,000 active employees and over 50,000 retirees. The cost of providing coverage to this group and their dependents exceeded \$410 million in 1991. Accompanying me is Sharon Canner, NAM's Assistant Vice President for Industrial Relations. I am pleased to appear today on behalf of NAM's 12,000 member companies, 8,500 of whom have fewer than 500 employees. (I ask that the full text of my testimony, copy of our survey, resolution on health reform and medical liability provisions be included for the record.)

We commend you, Mr. Chairman, for convening this hearing today to address the problems of health costs and the impact they have on America--employers who pay the bills, on jobs and the persons who lack access to affordable health coverage. The current work being done by President Clinton's Task Force on National Health Reform gives us encouragement that we may begin to solve this enormous problem in the not too distant future.

This testimony will highlight a 1992 NAM membership survey on health costs and reform, discuss the impact of costs on corporations and comment on improving the system.

HEALTH CARE COSTS, REFORM AND NAM MEMBERS

Last summer the NAM conducted a survey to determine prevailing attitudes toward the rising costs of health care and current health care reform proposals. Of the responding companies, 70 percent had up to 299 employees, 12 percent had 300 to 9999 employees and 18 percent had over 1000 employees. Health coverage is offered by over 97 percent of respondents. Smaller companies--with 50 or fewer employees--were only slightly less likely to offer coverage (93 percent) than larger companies (98 percent).

Costs. Health costs (expressed as a premium or self-insured equivalent) rose 15.5 percent in 1989 and 1990 and 15 percent in 1991. This represented an amount equal to 26.3 percent of net

profits in 1989, 28.4 in 1990 and 31.3 percent in 1991. Costs are rising at a rate three times general inflation. Certainly, corporate profits on average are not rising at this rate.

As a percent of payroll, respondents indicated that in 1991, health plan costs represented an amount equal to 9.1 percent of payroll--the same for large and small employers alike. This figure represents health plan costs for active employees only, a number somewhat smaller than the figures generally seen in many surveys, which often include health plan costs for both actives and retirees.

Survey participants were also asked whether they would be likely to drop health care benefits if costs continue to rise as they have over the past five years. A majority (53.3 percent) stated that such drastic action was not very likely, while 13.4 percent felt that it was somewhat likely, 6.5 percent felt that it was very likely, 11.7 percent stated that no change was planned and 4.1 percent said they did not know. Clearly the cost problem is a major issue that must be addressed very soon.

Causes of Rising Costs. Survey participants were asked to select from a list of 11 commonly recognized factors responsible for higher costs. Medical malpractice awards, an item we address in greater detail below, were cited by 85.1 percent of respondents. Fraud and abuse was stated by 77.6 percent of the respondents, physician and hospital fees were selected by 73.4 percent and 73.3, percent respectively. Other factor chosen by a majority of the survey respondents included the widespread use of expensive technology/high intensity of services (63.4 percent), unhealthy lifestyles such as smoking, drug use, driving without seat belts, etc. (56 percent) and the cost of medications (51.9 percent). Other items mentioned were lack of practice guidelines for physicians, fragmentation of the health care system, the fee-for-service reimbursement system and government tax policy.

Medical Liability. The fact that members selected medical malpractice awards is not surprising. While we do not believe that malpractice awards are the largest contributor to health costs, we believe that defensive medicine--the extra tests and treatments ordered by physicians to protect against lawsuits--do add significantly to the costs of medical care. Lewin/VHF, Inc. reported in January that over the next five years from \$7.5 billion to \$76.2 billion (mid-range estimate of \$35.8 billion) could be saved if we were to enact medical liability tort reform. This sum of money would go a long way to help finance coverage for the 37 million uninsured. To that point, we attach a list of essential principles for medical liability tort reform that a number of states have found successful in addressing medical liability concerns.

Reform Measures. NAM members reconfirmed their support for universal coverage--82.7 percent agreed that everyone should have coverage for affordable, necessary and appropriate health care. Over one-half (57.5 percent) felt employers should continue to be the primary sponsors of health benefits for their employees.

Over three-quarters of respondents (78.4 percent) felt that the system was in need of fundamental reform, but there was not clear agreement on what changes are necessary. The level of support for individual approaches was limited, but when coupled with other specific reforms, support increased.

Survey responses are reported here not to argue for a specific proposal at this time, but to point out that employers, driven by health costs at three times general inflation, are nearing a point of no return. They now seem willing to contemplate previously unpopular reform options, for example:

- 25 percent favored play-or-play as a stand-alone measure; (While this option is not on the table at present, similar responses could be expected for an employer mandate in general.)

- 55.3 percent favored play-or-play if combined with other elements of reform (for example, medical liability tort reform, quality and administrative initiatives, cost containment);
- One-third supported national spending caps on health care, again within the context of overall reform;
- 32 percent supported limiting the tax-free nature of employee health benefits for the employee if revenues were used to expand coverage for the uninsured, but limiting the employer deduction was favored by only 27 percent.
- 42 percent supported a system of binding negotiation with both private and public payers as a means to eliminate cost-shifting.

Cost-Shifting. As the above item points out, cost-shifting is a major concern for NAM members. Of the 1991 employer bill for health care, 28 percent or \$11.5 billion (Lewin/VHI, Inc. study) was due to cost-shifting resulting from underpayment by Medicare and Medicaid to doctors and hospitals, from manufacturers' cost of providing care for workers' dependents employed by non-providing employers and from having to pay for some of the nearly 37 million uninsured persons. Cost-shifting is a particular burden for manufacturers, most of whom provide coverage. It is an issue that must be addressed within the context of broad system reform.

IMPACT OF HEALTH COSTS ON EMPLOYERS

The fact that the United States spends more on health care than the other 23 nations belonging to the Organization of Economic Cooperation and Development (OECD) continues to confound policymakers concerned with the U.S. position in global markets. At the same time, the United States ranks higher in infant mortality and lower in life expectancy and fails to cover all of its population. Some point to our cultural diversity, crime rates, substance abuse and other social problems, noting that contrasting the United States with other industrialized nations amount to an "apples and oranges" comparison.

Nevertheless, U.S. firms, many of whom sponsor workplace benefits, view with dismay annual health cost increases three times general inflation and higher. While difficult to quantify, there is a growing belief that as a result of increased spending on health care, less is being spent on upgrading plant and facilities, research and development, training/retraining and other critical business investment. In short, while business has to pay increasing amounts to keep workers healthy, the true price may be borne by other facets of production that are not funded to the extent necessary to keep the U.S. business economy competitive. Rising health costs may affect employers in different ways; for example, the degree to which firms may choose to pay more overtime, rather than hire new workers because of the potential health benefit costs. This reluctance to hire may contribute to higher unemployment rates.

There is also another aspect to health care spending--the value of health status improvement obtained through investment in health benefits. Gains in worker productivity and well-being must be balanced with the cost of spending on health care. This is important to consider when determining the content of a standard minimum benefit package as part of national reform legislation.

TOWARD AN IMPROVED HEALTH CARE SYSTEM

As excerpts from our survey show, some significant changes in thinking are occurring among some manufacturers and there is an urgent desire to enact comprehensive health care reform. To guide us in moving in that direction, the NAM Board of Directors on February 13 approved a resolution which calls for a comprehensive reform package that should include, but not be limited to universal coverage, medical liability tort reform, administrative and quality initiatives, and implementation of cost containment measures to both address corporate cost increases and cost-shifting.

The resolution indicates NAM will be flexible in reviewing reform proposals. We will look at proposals in their entirety and not immediately reject them because we may oppose some of the individual provisions. Rather, we will evaluate proposals to determine what is in the long-term interests of the NAM membership and the nation to increase access to health care without jeopardizing quality, while constraining costs. Similarly, other groups concerned with reform must also take the broad view, and compromise when necessary so we can achieve reform before we further mortgage our economic futures.

As the debate goes forward, we urge you to carefully evaluate various solutions, particularly health care financing mechanisms and their potential impact on manufacturers. For example, these mechanisms could well affect wages, employment, profit, price and trade flow changes. Ultimately, we must fashion a health care system that reduces the high rate of cost increases for American business and preserves our future economic viability and capacity to support other essential national priorities.



RESOLUTION ON HEALTH SYSTEM REFORM

(approved by NAM Board of Directors)

February 13, 1993

The National Association of Manufacturers finds that health care spending, which passed the \$800 billion mark in 1992 and consumed over 14 percent of GNP, increasingly and adversely affects job creation and manufacturers' profits. NAM members experienced a 15 percent health cost increase in 1991 and in that year health care costs amounted to 31 percent of corporate net profits, according to our recent membership survey. Of the manufacturers 1991 bill for health care, 28 percent (\$11.5 billion) was due to cost-shifting resulting from underpayments by Medicare and Medicaid to doctors and hospitals, from manufacturers' cost of providing care for workers' dependents employed by non-providing employers, and from having to pay for some of the nearly 37 million uninsured persons (97 percent of NAM members provide health care coverage). Other cost-drivers of the system include quality problems, such as unnecessary and inappropriate care, estimated to add 10 to 30 percent annually to health costs and a flawed medical malpractice liability system in which doctors order more tests and treatments to protect against lawsuits.

In October 1991, the NAM Board endorsed 10 principles for reform which directly speak to these concerns with the cost, quality and access to health care. Member responses to our recent survey showed changes in thinking about some of these principles but also showed a continued urgent desire for a comprehensive health care reform package. This package should include, but not be limited to, universal coverage, medical liability tort reform, administrative and quality initiatives, and implementation of cost containment measures to both address corporate cost increases and cost-shifting.

We will use the 10 principles as benchmarks against which to judge health reform legislation. Further, as a means to bring health costs under control and expand access, NAM supports the concept of managed competition which seeks to make the marketplace work through selective regulation and aggressive use of managed care.

We recognize that health reform must be multi-faceted and proposals may contain certain elements which we have traditionally opposed. For example, the NAM recognizes that any truly comprehensive reform of the U.S. health care system--one, for example, that achieves such significant goals as controlling costs, expanding access and eliminating the cost-shift to manufacturers--is almost certain to require changes in the way health care is financed. On this issue, NAM is prepared to be flexible. Like other groups concerned with the issue, we will look at proposals in their entirety rather than individual elements. In keeping with the recommendations of the Executive Committee of the Board of Directors, this will require flexibility to determine what is in the long-term interests of NAM membership and the nation to increase access to health care without jeopardizing quality, while constraining costs.

*National
Medical Liability
Reform Coalition*

February 1993

NATIONAL MEDICAL LIABILITY REFORM COALITION

**Medical Liability Reform
Essential Provisions to be Included in
Federal Health System Reform Bills**

It is essential that comprehensive health system reform include effective medical liability reform, if cost containment and health care access objectives are to be achieved. The medical liability component of a comprehensive health system reform proposal should contain the following provisions:

1. Patient Safety Reform

- States would be required to establish mandatory patient safety programs
- Licensed professionals must participate at least once every three years in programs tailored to their particular profession and specialty
- Each liability insurer must provide or endorse risk management programs to its insureds
- Each health care facility or institution is required to have in effect a risk management program

2. Alternative Dispute Resolution (ADR)

- Federal support of state demonstration projects to evaluate the merits of ADR proposals designed to divert claims from the civil justice system and resolve them faster and more cost-effectively
 - Federal government to evaluate after 5 years
-

3. Practice Parameters/Guidelines

- Federal support for the evaluation of present and future state demonstration projects to examine the potential for practice parameters/guidelines to improve patient safety and discourage defensive medicine
- Federal government to prepare a report after 5 years

4. Uniform Standards for Medical Liability Claims

- A) Periodic payment of future damages over \$100,000
- B) \$250,000 limit on non-economic damages
- C) Mandatory offsets for collateral sources
 - Claimant gets credit for out of pocket expenses paid to acquire the collateral source
- D) Plaintiff lawyer fees limited by sliding scale
- E) Proportionate liability among all parties
 - Each defendant is liable for the percentage of damages that he or she caused
- F) Statute of limitations
 - Two year "reasonable discovery" rule with 4 year statute of repose
 - Special exception to statute of limitations for minors, which would allow up to 4 years for children under 6 to initiate claims
- G) Special obstetrics rule for drop-in patients
 - If a health professional has not previously treated a patient for pregnancy, burden of proof is "clear and convincing evidence"
- H) Expert Affidavit
 - Any claim filed in court or an ADR proceeding must be accompanied by an affidavit from an individual qualified to be an expert witness asserting that the claim has merit

Federal Preemption of State Law

The above uniform standards of federal law preempt corresponding provisions of state law unless the latter are more effective. State law is preempted whether or not a state participates in ADR or practice parameters/guidelines demonstration projects.

Scope of Reform

The above reforms should apply to any claim arising from health care services offered by health care professionals or institutional providers in any state or territory.

All claims arising from the delivery of blood services should be included in this reform legislation; suppliers of blood services should be included in definition of health care providers.

Product liability claims should not be subject to the provisions of this medical professional liability reform legislation.

Reforms do not create a federal cause of action or otherwise alter federal court jurisdiction or state choice of law and venue.

SUPPORTING ORGANIZATIONS

American Academy of Family Physicians
 American Academy of Orthopaedic Surgeons
 American Academy of Pediatrics
 American Association of Blood Banks
 American Association of Nurse Anesthetists
 American College of Cardiology
 American College of Obstetricians & Gynecologists
 American College of Physicians
 American College of Radiology
 American College of Surgeons
 American Dental Association
 American Fertility Society
 American Group Practice Association
 American Healthcare Systems
 American Hospital Association
 American Medical Association
 American Osteopathic Association
 American Podiatric Medical Association
 American Thoracic Society
 American Tort Reform Association
 MMI Companies, Inc.
 National Association of Manufacturers
 National Association of Pediatric Nurse Associates & Practitioners
 National Council of Community Hospitals
 Physician Insurers Association of America



Washington Business Group on Health

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The National Association of Manufacturers' testimony amply states employer cost problems, particularly the results of cost-shifting. Small employers, in particular, are finding it increasingly difficult to control the cost of health benefits. Large employers are making some in-roads by utilizing health systems that actively manage care, but they too are unable to fully control health costs for their employees. A recently released Foster Higgins survey found that use of various managed care alternatives held cost increases for employers in the single digits last year. The annual increase for HMOs was 8.8%. Admittedly, even these results are based on some degree of cost-shifting as indemnity products are often chosen by sicker individuals or individuals who are already working intensively with a particular provider. Indemnity product increases were 14.2% and as a result total health benefit costs rose 10.1%.

Provider and purchaser cost-shifting is out of our control. A fragmented delivery system allows costs to shift between providers and a fragmented purchaser market allows cost shifting between payers. Employers understand that to truly control costs purchasers and providers need to be organized in a manner that encourages meaningful negotiation.

Pressure on employers to control their employee benefit costs has led them to adapt a variety of innovative techniques. WBGH convened a group of employers to develop a vision for system reform based on their experience. From that meeting came support for the WBGH vision of the future health care delivery system. Care will be delivered through organized systems of care, that are fully integrated systems that provide the full continuum of care through a panel of carefully selected multidisciplinary providers, and are held accountable for the cost and quality of the care they deliver. These systems should be utilized by both public and private payers. To address the problems of small employers, WBGH supports the use of Health Insurance Purchasing Corporations for employers of 100 or less. This will give them the same economies of scale currently utilized by large employers.

Within the next two weeks WBGH will be releasing a detailed description of our concept of the new delivery system. We thank you for the opportunity to submit this statement and look forward to working with you to making affordable, quality care available to all Americans.

Chairman STARK. I want to thank the witnesses for their statements. Wally, we have two calls from the Senate where your services are also needed. The members have agreed, and if it is agreeable to the witnesses, to dismiss the panel so that Wally can testify. We would ask the witnesses to give us the opportunity to mail them questions to be responded to in the printed record. I am sure we would all appreciate it, and we can make our colleagues in the other body happier by letting you go without the arduous task of responding to us this morning.

If that is agreeable, I thank all of you. And I do want to find out, for instance, whether NAM can transfer their impetus to the NFIB; how it is working with union pilots, if that is so bad after all; what Chrysler is doing—a lot of good questions to talk about. We will put them off to another day. I thank the panel very much.

[Questions submitted to the panelists and responses follow:]

**SUBCOMMITTEE ON HEALTH
HEARING ON HEALTH CARE REFORM: THE ECONOMIC IMPACT OF RISING
HEALTH CARE COSTS
March 2, 1993**

Questions For Chrysler Corporation

- I. Mr. Maher, you stated that the sharp differences in international health care costs pose major competitive problems for our country. Dr. Reischauer, in earlier testimony, stated that health care costs were not a factor in international competitiveness because the costs were absorbed by workers. Please explain why Dr. Reischauer is mistaken?

Answer

First, Dr. Reischauer did not say that health care costs were not a factor in international competitiveness. Not only did he testify that "unexpected increases in costs can temporarily affect employment, profits, and international competitiveness", but he further acknowledged that "certain firms, such as those with abnormally high health costs for retirees", (in his oral presentation he included the auto industry in this group), "may find themselves at a disadvantage because they might have a difficult time shifting such costs onto their current labor force".

A classic example of how mature industries, those with older workers and large numbers of retirees, are particularly disadvantaged by the U.S. health care system, can be seen when you examine how they are impacted by cost shifting. For example, cost shifting that results from government's failure to provide health coverage for all the poor, and from government's failure to pay providers fairly under the Medicaid program, is quite clearly a form of indirect taxation. However, consider the difference between how taxes are levied and how health costs are shifted. Taxes are usually levied in a way to spread the cost of meeting various societal needs across a very broad tax base. Further, other than consumption type taxes, taxpayers usually do not have the luxury of opting not to pay a tax. The U.S. health system, however, through the many opportunities it presents to shift costs, in effect levies a tax which is applicable only to private sector health care bill payers. If you want to avoid "the tax," all you have to do is to cease being a bill payer. As noted in Chrysler's statement and testimony, for U.S. manufacturers the "tax rate" is now 28%. As more and more businesses drop coverage, as Medicare and Medicaid continue their cost shifting, the "tax rate" goes up. Worse yet, this outrageous "tax" is not even spread fairly among the private sector bill payers getting stuck. Is this "tax" based on ability to pay? Is it based on how large the business is? Is it based on the size of the employer's payroll? No. It is based on the size of the employer's health care bill. In other words, it is based on how old the workers are, how sick they are, how many children they have, and how many retirees the employer has. In short, it is extraordinarily punitive to mature American firms and creates a most unfair competitive disadvantage which no foreign enterprise faces.

Clearly, therefore, Dr. Reischauer's statements are not applicable for individual industries which have to bear the burden of their own health costs rather than having such costs spread over an entire economy, including products imported into that economy.

Notwithstanding all of the above, this question misses the essential thrust of our testimony. Our testimony was focusing, not only on the impact of high health costs on Chrysler Corporation, but in addition the debilitating impact such costs have on our entire economy. It will do little good for our country's economy if business merely shifts its excessive cost burden to employees. It makes little difference whether this cost shifting takes the form of reduced wages, reduced benefits, higher prices, reduced investment in employee training, reduced investment in new productive capacity, or a combination of all of the above. The losers are the citizens of this nation and, in turn, the businesses of this country. This country **depends** on employee/citizen/consumers to drive our economy. Accordingly, it is suicidal to pursue a policy which appears to say that no harm comes to our economy, and to the strength of the businesses which depend on a strong U.S. economy, if we continue the status quo of permitting government to shift costs to business, permitting businesses who do not offer insurance to shift costs to employees and to other employers who do offer health benefits, and finally sending a signal to businesses that do offer benefits and who are encountering competitive pressures, to go ahead and just shift costs to their employees. To pursue such a policy is to fail to focus on its inevitable result: a continuing erosion of the standard of living of American citizens, which in turn will cause substantial harm to American businesses. Weak businesses will not succeed in a global economy.

2. Mr. Maher, you concluded that we need "to bring our health care costs in line with our major trading partners." Do you believe Canada should also bring its housing costs or Japan its food costs in line with the United States to have a level playing field?

Answer

No, nor do I believe Germany should bring its fuel prices in line with Saudi Arabia's. Some countries are blessed with comparative advantages, and some with dramatic disadvantages. The issue, however, is can you do anything about it. For some countries, these advantages are based on resource endowments and little can be done to change them. But for other countries, their strengths lie in the efficient systems they create. If you can and you want to compete, you strive to be the best, to be the most efficient. Germany and Japan do not have lower health costs because of any natural comparative advantage. They merely have what most every other nation on earth has, other than the United States, a health policy which focuses on, among other things, keeping health costs affordable for their economies and their citizens.

Some countries do not take steps to become efficient in certain areas, whether it be food, housing, or anything else, and as a result their citizens and perhaps their businesses are disadvantaged. This is no reason for our country to avoid tackling inefficiencies which are clearly correctable. We should not take a position that,

simply because we have natural advantages over some countries in some areas, we should ignore inefficiencies of our own creation because we may still be "net" ahead of the game. No truly successful business would pursue such a strategy, nor should our country.

U.S. health care costs are, by **any** measure, excessive, and the system riddled with inefficiencies. No country on earth is seeking to emulate our system as it exists today. Unless you subscribe to the position that the system is not inefficient, or that we should not worry about such inefficiencies, fixing it is an economic imperative.

QUESTIONS FOR ALL PANELISTS

1. Is it fair to say that the business community now believes that a more aggressive approach is needed to control health spending, with government involvement?

Answer

Yes, certainly this is the position of Chrysler Corporation as well as that of Ford Motor Company and General Motors Corporation. The fact is that no nation has embarked on a program to provide all citizens access to health care without concurrently adopting a strategy to control aggregate national health care spending. The central lesson of our experience with health care, and health care reform, over the past twenty years is that in the absence of system-wide constraints, costs get shifted. It is easier to shift costs than to control them -- and we have learned that if they can be shifted, they will be. Piecemeal attempts to tamp down costs are illusory; savings in some sectors or for some consumers of health care services just get offset by increased costs elsewhere. This requires the public and private sectors to work in concert.

Further, we believe that, consistent with the above, effective cost control requires an enforceable national budget process to limit spending. Such budget discipline is fully consistent with the implementation of managed competition.

2. Why do businesses continue to rely on less successful models (compared with staff model HMO's), such as PPO's and IPA's?

Answer

Many businesses offer employees choices of plans, including HMO's, PPO's and IPA model HMO's. It has been our company's experience that the relative larger enrollment in PPO's and IPA model HMO's, compared with some staff model HMO's, relates directly to the larger number of providers available to enrollees in such plans. It should be noted, however, that a large number of Chrysler employees are enrolled in a staff model HMO in the Detroit area. This HMO has been in business a number of years, has facilities located throughout the metropolitan area, and has a large number of providers.

3. (Question re international competitiveness)

See answer to Chrysler question 1, above.

4. Do you anticipate that employers will continue to cut back on benefits for employees and dependents, to hire more part-time workers, to pay for over-time rather than hire additional workers and incur benefit costs for them?

Answer

In the absence of national health reform and controls over aggregate health spending, employers will continue to take any and all steps available to them to reduce the impact on them of escalating health costs. This includes curtailing benefits for employees and dependents, and relying more on part-time workers and over-time, rather than hiring additional personnel.

5. If 20 percent of employers dropped their health benefit plans, how many individuals are likely to find themselves with a substantial reduction in health benefits?

Answer

The answer to this question is, in part, dependent on the size of the employers which drop their health benefit plans. However, in addition to the employees of such firms who will be adversely impacted, there will also be an adverse ripple effect. Specifically, the latter will be caused by an exacerbation of the existing cost shifting which impacts U.S. businesses, and in particular those businesses in the manufacturing sector. (See answer to Chrysler question 1, above, in this regard). It is quite likely that such an increase in cost shifting will either cause additional businesses to drop coverage, or will so burden them that their businesses will suffer, producing an adverse impact on employment and, in turn, health coverage.

6. Won't cutbacks in retiree health benefits increase the number of uninsured early retirees who are not yet eligible for Medicare?

Answer

Yes, and in addition it will exacerbate the cost shifting problem referred to in the answer to Chrysler question 1, and question 5, above, with the same adverse consequences.



March 29, 1993

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The Honorable Pete Stark
Chairman
Ways and Means
Subcommittee on Health
1114 Longworth House
Office Building
Washington, D.C. 20515

Dear Mr. Stark:

Attached you will find our responses to the questions posed from the Subcommittee on Health.

Once again I would like to take this opportunity to thank you for allowing us to testify before the Subcommittee regarding the high costs of health care and its impact on corporations such as Federal Express.

If you have questions or need additional information, please do not hesitate to contact me.

We look forward to working with you and the administration on a solution that will truly impact our health care system.

Sincerely,

A handwritten signature in dark ink, appearing to read "Aug Lauer".

August C. Lauer
Federal Express
Sr. Manager
4009 Airways Blvd.
Memphis, TN 38116
901-922-2052

Attachments

SUBCOMMITTEE ON HEALTH
HEARING ON HEALTH CARE REFORM:
THE ECONOMIC IMPACT OF RISING HEALTH CARE COSTS
March 2, 1993

FEDERAL EXPRESS

WITNESS: August Lauer

1. Mr. Lauer, you described the experience of Federal Express with managed care programs.

What has been the employee response to managed care?

In general, people do not like change. They are more comfortable keeping things the same. However, Federal Express employees are ingrained with a philosophy of change - constantly changing in order to satisfy our customers. This commitment to change, this philosophy of satisfying our customers, whether they are external customers or our internal customers (our employees) helps explain why our employees are more willing to accept change.

Another reason we have been so successful with the implementation of new programs such as managed care, is that we found out over the years, that if you explain "why" you are changing a particular program, your employees are more willing to accept it.

An example of where we have implemented such a change would be in our psychiatric coverage. Initially, Federal Express offered a plan like most other corporations, allowing our employees to select their own care, but limiting the number of visits, etc. allowed by the employee.

Today, through our managed care emphasis, we have implemented a new psychiatric program which allows our employees to continue to receive the care they need while meeting the corporation's objective of quality care at an affordable price.

The current program now allows each employee to receive "personalized care" dependent upon their individual situation. If you need more than 30 visits, then you will receive more. If your treatment calls for less visits, then you receive less.

While this program has been successful according to our employees, the company has also been able to share in the success of the program, as over the last three years, we have seen a 25% decline in psychiatric costs. By controlling access to the system, we have been able to increase our benefits while at the same time reduce costs through negotiated rates.

In January of 1993, we implemented a managed care network in California where we have approximately 10,000 employees. It is too early for us to fully determine our employees' reaction to this new network. However, if the initial reception of the program is any indication of their satisfaction (approximately 80% of the California employees chose the managed care network over our indemnity plan), we will be well on our way to meeting our objective of satisfying our employees needs at a cost affordable to both the employee and the company.

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FEDERAL EXPRESS

WITNESS: August Lauer

2. **One of the ongoing debates on the national reform front is the ability of managed care to achieve the kind of savings that you described on a national level.**

Does your experience imply that managed care can provide across the board savings?

Federal Express has been able to see significant reductions in costs through our managed care network. As mentioned earlier, over the past three years, we have seen our psychiatric costs decline 25%. This program, which controls access to the system, is just one part of our managed care network.

Other programs in our network, such as our HMO offerings and our PPO offering in Memphis, Tennessee, have allowed us to witness costs savings to both the company and our employees.

However, implementation of programs such as HMOs and PPOs call for additional time, administrative effort and resources and immediate results are not likely.

It is important to remember the purpose of managed care networks and that is to develop a long term solution to our current health care problem. The impact of everyone being covered by a managed care plan will lead to greater efficiency in the system and costs will eventually level out or potentially decrease. We feel that is an investment we cannot afford *not* to make.

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FEDERAL EXPRESS

WITNESS: August Lauer

3. Mr Lauer, you indicated that companies such as yours need help in implementing national health care reform. Can you be more specific? What policies would give you and other employers the tools to better contain costs?

Addressing the issues stated below, will help corporations contain costs and positively influence our health care system.

1. ERISA PREEMPTION

Federal Express, like most other large corporations, is in favor of *national* health care reform. As a multi-state employer with over 80,000 employees nationwide, reform on an individual state basis would be close to impossible for us to administer. Therefore, we are in favor of keeping the ERISA Preemption, which currently allows self-insured plans to be exempt from state mandates regarding health care, intact and not allowing it to be opened. There are currently several pieces of legislation pending in Congress now which would amend ERISA Preemption. By opening up ERISA, we will be taking a step backwards in our quest for *national* health care reform.

2. Limiting individual tax exclusion

By limiting an employer's deduction, corporations are incited to offer only the "basic" health care plan to their employees. The impact could result in employees receiving less benefits tomorrow than they currently have today. This could lead to great employee relations strife for corporations currently offering competitive benefits. We ask that alternatives to this limitation be considered. Measures should be taken that cause employees and individuals to become more conscious of the cost of health care benefits and services and knowledgeable of the benefits they require.

3. Universal access to health care and an end to cost shifting

Universal access to health care is needed in order to prevent creation of cost shifting from the uninsured and government-sponsored programs. This could be achieved through review and improvement of eligibility standards and reimbursement rates of Medicare and Medicaid. In order for the health care system to work and work for everyone, then *everyone must pay their fair share.*

4. Remove legal and administrative barriers

Lastly, remove the legal and administrative barriers that increase costs for consumers and providers alike. For example, there is a need for uniform electronic claims processing. There is also a need to create an alternative dispute resolution system for medical malpractice claims and the development of practical parameters to be used as an affirmative defense in malpractice cases.

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FEDERAL EXPRESS

WITNESS: August Lauer

1. Over the years, the business community has tried any number of strategies to reduce their health care costs.

Today we have just heard that 80% of employers surveyed by the National Association of Manufacturers believe that fundamental reform is still needed to control costs.

The NAM testimony further states that nearly one third of surveyed employers would support national spending caps to control the growth in health spending.

Is it fair to say that the business community now believes that a more aggressive approach is needed to control health spending, with government involvement?

Many corporations, such as Federal Express are voluntarily implementing programs to control costs and provide quality care. However, as impressive as our cumulative efforts are, they are not enough to sufficiently reduce health care costs.

This is because too many of the factors contributing to the increase in our health care costs are outside of our control. Cost shifting from lack of coverage and lower provider reimbursement rates in government sponsored health care programs are simply not issues that we, as corporations, can address on our own. We recognize this and ask your support in helping us achieve national health care reform.

2. Previous testimony from the Congressional Budget Office indicates that only tightly controlled group or staff model HMOs have been successful controlling health care costs.

Why do businesses continue to rely on less successful models, such as PPO's and IPA's.

We recognize that it is not possible for one plan to fit 80,000 employees' needs, so, where possible, we offer more than one managed care plan to our employees.

We are very aware that not all employees welcome the HMO "gate keeper" philosophy. Many employees enjoy the freedom of "choice" they have when they participate in a PPO. This same rationale applies to many employees who do not embrace the clinic environment of staff model HMOs.

Because we feel it is necessary to offer our employees a choice in the health care services they receive, and because of our geographic distribution, we offer our employees alternatives in their managed care selection.

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FEDERAL EXPRESS

WITNESS: August Lauer

3. Economists would argue that higher health care costs do not cause problems for international competitiveness, since the higher costs come out of the employees' pockets.
How do you respond to that argument.

Where we have protected our employees as much as possible from the impact of rising health care costs, there is only so much we, as a corporation, can continue to absorb the costs without the impact being felt by either our customers, our employees or our shareholders.

4. Do you anticipate that employers will continue to cut back on benefits for employees and dependents?

The impact of rising health care costs has been tremendous, not only for Federal Express but for other corporations as well. Federal Express has seen its health care costs increase 236% in just six years. Even though we are doing our share to control costs by implementing managed care plans where possible, it is not enough. We have not been able to sufficiently reduce health care costs. This impacts our ability to increase resources to other aspects of our total compensation package, or to divert our resources to other areas of concentration for Federal Express.

Isn't it true that employers have an incentive to move toward part-time workers, and pay for over-time, rather than hire additional workers, and incur the cost of health benefits for new employees and their dependents.

Federal Express employs 94,000 employees worldwide. 80,000 of those employees are located in the United States where each and every one of them, part-time and full-time, are provided with a comprehensive and competitive benefits package at no cost to them.

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FEDERAL EXPRESS

WITNESS: August Lauer

5. The testimony of the National Association of Manufacturers indicates that 20% of surveyed employers are likely to drop benefits if costs continue to rise.

If this were to occur, about how many individuals would find themselves with a substantial reduction in health benefits?

Based on the information stated above, we are not able to calculate any direct impact to Federal Express. However, additional cost shifting from lack of employee coverage (from other employers) may very well impact our ability to absorb additional health care costs.

6. As you all well know, there have been reports in recent months of cutbacks in retiree health benefits. Some plans are increasing employee contributions. Others have eliminated benefits altogether.

Won't this increase the number of uninsured early retirees who are not yet eligible for Medicare?

With the implementation of FAS 106, corporations are feeling the financial pressure of funding future retiree health benefits. This pressure coupled with the uncertainty of spiraling health care costs (when they will be contained) leads many employers to curtail promises for future benefits.

With national health care reform, the second factor in this uncertain equation will be addressed and will hopefully provide a means by which all Americans can receive health care coverage through public and private plans.



National Association
of Manufacturers

Sharon F. Canner
Assistant Vice President
Industrial Relations

March 23, 1993

The Hon. Pete Stark
Chairman, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Rep. Stark:

We appreciated the opportunity to testify before the Subcommittee on March 2 on the economic impact of rising health costs. Unfortunately, a scheduling conflict precluded the followup Q&A period. It was our hope to expand on the impact that health costs are having on firms and to talk more about NAM's position. Hopefully, we can schedule some time in the near future to discuss these items. The following are NAM's responses to written questions posed by the Subcommittee.

1. **Business community perspective on whether a more aggressive approach is needed to control health spending, with government involvement.** Certainly, a more aggressive approach is needed to control costs, but defining the appropriate role for government is difficult. Micro-management by government could interfere with private sector efforts of quality improvement, episode of illness pricing, physician and hospital risk-bearing contracts and similar creative attempts at cost management. Government regulation can make immediate changes in controlling costs, but the long term side effects may serve to exacerbate existing problems.
2. **Business' heavy reliance on PPOs and IPAs despite CBO testimony that such models are less successful in controlling costs than tightly controlled group or staff model HMOs.** While many businesses recognize the superior cost efficiencies of group and staff model HMOs, they are not always at liberty to contract with these entities for various reasons: (1) The cost-savings of more restrictive HMO models must be balanced against employee relations issues; (2) Union dictates may prevent use of HMOs; (3) The local medical market area may lack suitable HMOs; (4) Employers have less control over group and staff model HMOs; (5) Large multi-site employers find it easier to deal with one firm (for example, a CIGNA or Prudential) which operates numerous PPOs or IPAs across the country. Many group staff model HMOs often are limited to single locations.

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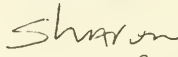
3. **Perception that health care costs do not cause problems for international competitiveness, but affect employees instead.** To some degree, higher health costs do come out of employee's pockets possibly resulting in delayed wage increases, but this issue is far more complex. Many American companies already provide more comprehensive benefits than their foreign counterparts both in and out of the United States. To remain competitive, some firms may absorb higher health costs by continuing to improve their productivity. Over time, however, productivity gains will not be able to offset high health costs. Both employees and American firms suffer under annual increases that are three times general inflation.
4. **Employer reaction to cost increases and benefit cutbacks.** In responding to cost increases some employers do make some cutbacks. Many, however, like Ameritech, have redesigned their plans with an emphasis on managed care. Employer response depends on the particular industry, the patterns set by competitors and whether there is a collective bargaining agreement in place. Anecdotally, we do know that some employers may use more part-time help and pay for over-time rather than hire new employees as a means to deal with health cost increases.
5. **NAM survey finding that 20 percent of surveyed employers are likely to drop benefits as a result of cost increases and the numbers of employees this would affect.** Based on a total population (2,973,438) of employees within the survey, an estimated 594,688 would lose benefits they had previously received from their employer if costs increased. It is important to note that this number only reflects the number of employers who took part in the survey, which was 1,305. Taken at its fullest potential, the number of employees being affected by cost increases would be an extremely larger number.
6. **Cutbacks in retiree coverage and the impact on early retirees not eligible for Medicare.** Cutbacks--benefit redesign changes--undertaken by some employers recently have been done because of extreme economic pressures. In some cases, failure to redesign retiree health plans would mean major benefit reductions for active workers. Average per-capita costs for Medicare eligible retirees will approach \$1,500 in 1993; for early retirees, those costs are close to \$4,000 and some companies pay as much as \$7,000 a year in health costs for pre-Medicare eligible retirees. (Washington Business Group on Health).

Retiree coverage must be balanced against the total demands placed on the firm--responsibilities to active employees, stockholders, consumers that purchase the firm's products or use its services as well as responsibilities to the community where plants are located. Most firms in the United States do not provide retiree benefits--25 percent of pre-Medicare eligible retirees and 16 percent of adults over the age of 65 receive health care benefits from previous employers. Primarily, only large firms provide retiree coverage. For most retirees, Medicare constitutes the only retirement health program.

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7. **Health, care spending and the impact on workers.** In his testimony, Dr. Reischauer points out that workers bear the cost of health care increases. Using this same reasoning, corporations don't pay taxes, individuals do and thus the consumer (the purchaser of Ameritech's services) pay for increased health costs. In addressing health care inflation, Ameritech has made aggressive use of managed care and educated employees to be better health care shoppers by providing information on health care providers. Arguing over who bears the cost of health care inflation does not solve the problem. Ultimately, employers, labor, consumers, providers and insurers must work together to attack the cost problem.

Sincerely,



Sharon Canner
Assistant Vice President

cc: Randy Hale
Vice President
Industrial Relations

Chairman STARK. We will continue with testimony from witnesses representing organized labor. We are pleased to have with us John J. Sweeney, the international president of the Service Employees Union; Charles Gerhardt, executive vice president of local 2100, Communication Workers of America, Baltimore, Md.; and Sigurd Lucassen, president of the United Brotherhood of Carpenters & Joiners of America.

I would also like to point out that one of our distinguished Members from Maryland, Mr. Cardin, had hoped to introduce Mr. Gerhardt, but Mr. Cardin also serves on the House Administration Committee, which is trying to cut our costs. As a result, we gave him a tardy slip today and allowed him to be there. He wanted me to acknowledge your presence, Mr. Gerhardt, and I am happy to do so.

Mr. Sweeney, why don't you lead off.

**STATEMENT OF JOHN J. SWEENEY, INTERNATIONAL PRESIDENT,
SERVICE EMPLOYEES INTERNATIONAL UNION, ACCOMPANIED
BY MARGUERITE CONNERTON, CHIEF ECONOMIST**

Mr. SWEENEY. Thank you very much, Mr. Chairman. I am president of the Service Employees International Union, and with me is our chief economist, Peggy Connerton.

Mr. Chairman, and members of the subcommittee, I welcome the opportunity to speak to you today about the number one issue driving the health care crisis; namely, the out of control rise in our health costs. Health care costs have forced the janitors, nurses aides, schoolbus drivers, and other hard-working individuals who make up our union to accept a declining standard of living, and there is little we can do at the bargaining table, employer-by-employer, to counter this trend.

Last fall, SEIU conducted a study based on calculations by the nonpartisan health economics consulting firm Lewin-ICF to examine the 12-year impact of health care cost on the wages and living standards of American workers. The study, entitled "Out of Control, Into Decline," is the first detailed damage report of the impact of runaway health care costs on workers' wages, cost profits, and Government deficits over the past decade. The analysis quantifies what many Americans have known intuitively for years; rampant health care costs are making havoc with our economy.

What would have happened to wages if health care costs had grown only as fast as the economy over the past 12 years? During that period health spending grew 50 percent faster than the overall economy. According to the data from Lewin-ICF, controlling health care costs would have reversed one of the most damaging economic trends of the last decade, the decline in real wages for most workers.

As shown on the first graph, if wages had not been lost since 1980 to excess employer health costs, the average hourly nonsupervisory wage would have been about 50 cents higher in 1992. If not for this excess spending on health care, most workers could have stayed even instead of losing ground. Working families have been paying the price for our country's failure to control runaway

health costs that squeeze family budgets and falling living standards.

According to Lewin-ICF, every working family with health insurance in the United States lost an average of \$8,398 since 1980 and took the equivalent of a 5-percent pay cut in 1992 alone. Exorbitant health care costs also undermine families' ability to save money. Savings rates and rates of home ownership for young American families have fallen precipitously since 1981, and college costs are becoming unaffordable for many families. But if the average working family had put in the bank the income lost through out-of-control health care costs, they could have saved almost \$12,000 from 1980 to 1992.

Businesses are also paying the price, as is shown in the second graph. In recent years employers' spending on medical plans has jumped to 61 percent of before-tax corporate profits, devouring resources needed to improve wages, productivity and capital investment. One-third of business health cost in 1992, about \$1,000 per employee per year, can be attributed to excess health care costs.

If we had controlled costs the way the rest of the world does, American business would be spending an average of \$2,000 rather than \$3,000 per employee per year. For small businesses who provide insurance, the savings would have been even more dramatic. If health spending had kept in step with the economy, businesses employing fewer than 10 employees would be paying \$2,600 per employee for health coverage instead of \$3,900, an annual savings of \$1,300.

Government budgets have also suffered due to the soaring health costs. For fiscally strapped State and local governments, out-of-control health costs have had a critical impact. Health care is the fastest growing expenditure item for State and local governments, with one-fifth of their budgets spent on medical care. If health care costs had been held in check, States would have an extra \$35 billion available in 1992. This would have enabled States to avoid damaging cuts in services and regressive tax increases.

All of the findings from this study point to the conclusion that long-term economic renewal in the United States is not possible without effective measures to contain health care costs. The underlying assumption in this study is health care cost increases can be limited to the rate of growth in the economy.

Several major health care reform plans now being debated propose to control costs through some form of global budgeting. Others continue to recommend reliance on market forces. The results of our study and our Nation's experience of more than a decade offer strong evidence that the market alone cannot do the job of containing health costs.

We share the concern of President Clinton and the members of this committee, and we hope that the time for delay and inaction is over and that we can work together to solve the health crisis in 1993.

Thank you.

Chairman STARK. Thank you, Mr. Sweeney.

[The prepared statement follows:]

STATEMENT OF JOHN J. SWEENEY, INTERNATIONAL PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION

Good morning. I am John Sweeney, President of the one million member Service Employees International Union (SEIU). Mr. Chairman, and members of the Subcommittee on Health of the Committee on Ways and Means, I welcome the opportunity to speak to you today about the number one issue driving the healthcare crisis, namely, the out-of-control rise in our health costs.

SEIU has been at the forefront of the national healthcare reform debate for many years. That's because escalating healthcare costs have forced the janitors, nurse aides, social workers, school bus drivers and other hard-working individuals who make up our union to accept a declining standard of living. And there's little we can do at the bargaining table, employer by employer, to counter this trend. Nothing short of a complete overhaul of our healthcare system will stem this decline and put us back on the road to economic growth and prosperity.

The problems working Americans are having with healthcare costs are well-documented. Health insurance benefits have become the toughest issue at the bargaining table, with rising costs crowding out other components of the compensation package -- cutting into worker wages and other benefits. Faced with escalating costs, employers have increasingly demanded that workers accept larger premium co-payments, higher deductibles and lower wage increases. As a result, healthcare costs are now the leading cause of labor disputes.

Last fall, SEIU conducted a study based on calculations by the nonpartisan health economics consulting firm Lewin-ICF to examine the 12-year impact of healthcare costs on the wages and living standards of American workers. The study, entitled "Out of Control, Into Decline," is the first detailed damage report of the impact of runaway healthcare costs on worker wages, corporate profits and government deficits over the past decade. The analysis quantifies what many Americans have known intuitively for years. Rampant healthcare costs are wreaking havoc with our economy.

The study determined that the tab for excess health costs since 1980 is \$1.2 trillion. This represents the portion of health cost increases that exceeded GNP growth throughout the 12 year period. These excess costs are one of the most significant contributors to our sick economy. That \$1.2 trillion represents money that could have gone to workers' wages to improve family well-being, to American businesses to improve their competitiveness in the global market, and to state and federal governments struggling with staggering budget deficits.

The stagnation and decline of American family incomes is one of the most powerful and well-known economic trends of the last decade. Adjusted for inflation, most workers earn less per hour today that they did in 1980 -- 4.4 percent less, on average.

Although slow productivity growth and structural changes in the U.S. economy are typically cited as the culprits behind falling wages, our study found that unchecked healthcare costs are also a major contributing factor.

What would have happened to wages if healthcare costs had grown only as fast as the economy over the past 12 years? During that period, health spending grew 50 percent faster than the overall economy. According to the data from Lewin-ICF, controlling healthcare costs would have reversed one of the most damaging economic trends of the last decade -- the decline in real wages for most workers.

If wages had not been lost since 1980 to excess employer health costs, the average hourly non-supervisory wage would have been about 50 cents higher in 1992. If not for this excess spending on health care, most workers could have stayed even -- instead of losing ground.

Working families have been paying the price for our country's failure to control runaway health costs with squeezed family budgets and falling living standards. According to Lewin-ICF, every working family with health insurance in the United States lost an average of \$8,398 since 1980, and took the equivalent of a five percent pay cut in 1992 alone.

Exorbitant healthcare costs also undermine families' ability to save money. Savings rates and rates of home ownership for young American families have fallen precipitously since 1981 and college costs are becoming unaffordable for many families. But if the average working family had put in the bank the income lost to out-of-control healthcare costs, they could have saved almost \$12,000 from 1980 to 1992.

Businesses are also paying the price. In recent years, employer spending on medical plans has jumped to 61 percent of before-tax corporate profits, devouring resources needed to improve wages, productivity and capital investment. One-third of business health costs in 1992 -- about \$1,000 per employee per year -- can be attributed to excess healthcare costs. If we had controlled costs the way the rest of the world does, American business would be spending, on average, \$2,000 rather than \$3,000 per employee per year.

For small businesses who provide insurance, the savings would have been even more dramatic. If health spending had kept in step with the economy, businesses employing fewer than 10 employees would be paying \$2,600 per employee for health coverage instead of \$3,900, an annual savings of \$1,300.

The impact of rampaging healthcare costs on business competitiveness is substantial. Since the United States devotes roughly one and a half times as much of our GNP to health spending as our major trading partners do, U.S. companies are finding it hard to maintain their competitive edge in the world market. So, in order to compete, businesses are under pressure to pass costs on to workers in the form of lower wages and higher out-of-pocket health costs. And inflated health costs also penalize mature U.S. industries that employ older, more experienced workers and have forced many companies to break their promises of lifetime coverage to retirees.

Government budgets have also suffered due to soaring healthcare costs. For fiscally strapped state and local governments, out-of-control health costs have had a critical impact. Health care is the fastest growing expenditure item for state and local governments, with one-fifth of their budgets

spent on medical care. If healthcare costs had been held in check, states would have an extra \$35 billion available in 1992. This would have enabled states to avoid damaging cuts in services and regressive tax increases.

Over the past 12 years, the failure to control healthcare spending has cost state and local governments a cumulative total of \$159 billion. This is money that could have been spent on improving schools, building roads, and investing in the skills of our work force.

The impact of excessive health costs on the federal budget is equally dramatic. If health spending were controlled to the rate of growth in the economy, the federal government would have saved \$79 billion in 1992 alone, enough to make a sizable dent in the budget deficit.

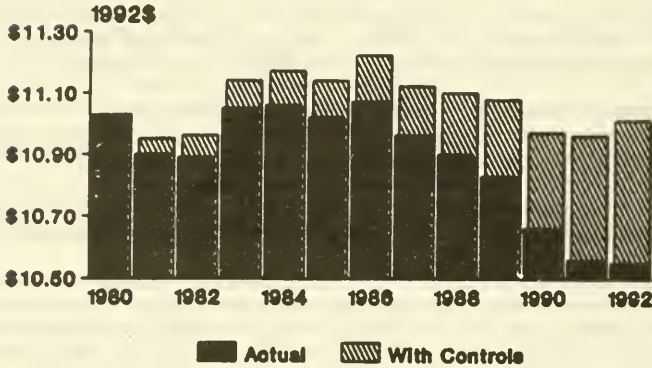
All of the findings from this study point to the conclusion that long-term economic renewal in the United States is not possible without effective measures to contain healthcare costs.

The underlying assumption in this study is that healthcare cost increases can be limited to the rate of growth in the economy. Although skeptics claim this is unrealistic, the experience of other countries has already proven our point. In fact, our major competitors, including Germany and Japan, did succeed in holding healthcare costs constant as a share of gross domestic product since 1980. Furthermore, the United States is unique among industrialized nations because it is the only country that to such a great extent relies on the private market to control costs.

Several major healthcare reform plans now being debated propose to control costs through some form of global budgeting. Others continue to recommend reliance on market forces. The results of our study and our nation's experience of more than a decade offer strong evidence that the market alone cannot do the job of containing health costs.

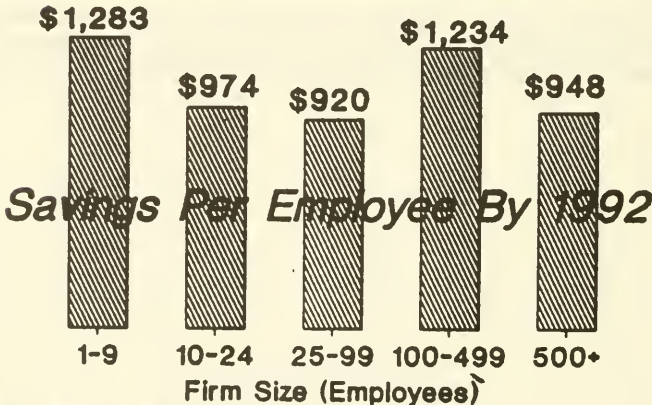
SEIU is encouraged by the amount of attention President Clinton is giving to national healthcare reform. We share his concern expressed during the State of the Union address that we cannot wait five years, or even one more year, to enact comprehensive healthcare reform. The time for delay and inaction is over; we must all work together to solve the health crisis in 1993. Our future economic well-being depends upon it.

Fall in Workers' Wages Due To Increase in Employer Health Costs



Source: SEIU; Lewin-ICF

Controlling Health Costs Would Have Cut Employer Spending By One Third



Source: SEIU; Lewin-ICF

Chairman STARK. Mr. Gerhardt.

STATEMENT OF CHARLIE GERHARDT, EXECUTIVE VICE PRESIDENT, LOCAL 2100, COMMUNICATIONS WORKERS OF AMERICA, BALTIMORE, MD.

Mr. GERHARDT. Mr. Chairman, Congressmen, my name is Charlie Gerhardt. I am the executive vice president of CWA, local 2100 in Baltimore. We represent about 1,400 workers in the telecommunications industry in Baltimore and central Maryland. Most of those people work for C&P Telephone Co., and we have a small population that works for AT&T.

Mr. Chairman, when I first received the request, the invitation to testify, I was told to prepare testimony on the overall effects of health care costs on CWA and its members. That is the nature of my testimony. It digresses a little bit from pure economics, and I am not an economist, but if you will bear with me, I will go through quickly and hit some of the high points.

Chairman STARK. Please do.

Mr. GERHARDT. CWA began to deal with health care costs as a major bargaining issue in 1983. In that year we put 650,000 people—and this comes under the heading of economic effect—650,000 people on the streets on strike with the primary issue being health care copays, open-ended health care copays, and they stayed out for 3 weeks.

Since that time our real wages have remained relatively flat or have fallen, if you adjust them for inflation. It has been very difficult if not impossible for us to bargain any improvements in other economic areas of our contracts or general agreements.

In 1989, 55,000 workers in the Bell Atlantic region, in the seven-State Bell Atlantic region, were on strike for over 3 weeks on health care issues, and in the same period, in the NYNEX region, there were 33,000 people on strike for 17 weeks.

At a local level, our local operates on a budget of about \$280,000 a year. In the year 1991 we spent between 12 and 15 percent of that local budget just to administer or to enforce the health care agreements with the employers and the people whom we represent. Currently I would estimate we spend about \$10,000 a year enforcing those agreements, and that is for 1,400 people.

We began actively trying to contain, through the collective bargaining arena, health care costs in 1983 and 1984, as I mentioned earlier. The first thing we tried was self-insurance. Because we bargain with large employers, it was possible for them to be self-insured. At that time the culprit was insurance premiums that were rising faster than the health care cost inflation rate, and that had a very short-term effect.

About the same time we went to coordination of benefits, which prevented double dipping or redundant insurance payments that had a moderate effect on holding the costs down for a short period of time, and then they started going back up again.

We went to preadmission review to make sure that hospitalizations were necessary. We did that on a mandatory outpatient basis so you avoided that additional hospital day. We let go our coverage for nonemergency weekend admissions, which was a common prac-

tice in the middle 1980s, aimed at reducing hospital costs. We went to mandatory outpatient procedures. None of those things worked. The hospital costs, which followed the insurance premiums, continued to rise.

We went to mandatory second and surgical opinions. Did not work at all. Didn't save a dime. We have no record of any surgeon disagreeing with the first opinion.

We also explored and rejected what we call cafeteria-style benefits, which are plans under which workers or employees pick and choose what insurance coverage they would like, what health insurance and other types of insurance. The reason we rejected those plans is because our research department felt as though if you allowed that to happen, that the low users would opt out of the plans and the funding would be reduced to the point where the high users could no longer be supported by the plans.

The C&P management did go to a similar plan and we have watched their benefits erode from the top. They no longer have high option benefits, and have gone through a grade-A shamle, and we suspect that is the reason, because of the erosion as people withdraw from the plan.

In 1990, we—in 1989, actually, after a 3-week strike, we negotiated very carefully a customized designed managed care network, and I became involved from the beginning in helping to implement a little bit in the design and a lot in the enforcement of the terms of that network. Under the terms of the agreement, our members have tremendous copays. If they don't follow the rules, there are tremendous restrictions on the use of providers.

I would like to just read verbatim from my testimony here and I will get it over as quick as I can. I would like to offer the premise first that for any serious health problem, to deny a patient some form of health insurance coverage is to deny treatment. Providers cannot work for free, and very few people have the personal financial resources to pay for even a modest amount of medical care.

Health care cost containment is a huge and complex economic problem and I am very much afraid it has a simple solution. If we deny payment, we control costs. By doing so, you also deny treatment. This is my experience with the current trend—incidentally, one of the committee members said something earlier about placing blame. I hope you will accept this as observed fact and not the placement of blame.

The testimony, as it goes on: The trend of denying treatment is widespread in our managed care network. In HMOs I have dealt with traditional indemnified insurance policies and, at least in the State of Maryland, in the Medicaid program.

I will outline—my testimony contains about eight examples. I will use four in the interest of brevity, and the first example is my wife, who is sitting behind me here at the table. Tema is a member of CWA. She is in her eighth year of full blown AIDS.

She is still working and our managed care network guidelines allow us the use of only one medical lab. Her monthly lab bill is about \$450 and it is a fully covered service. The plan administrator denied payments for her lab bills based on the fact that the lab was dishonest. However, they would not allow us to use any other labs in the State of Maryland.

Another problem she had was admission into hospitals. She has to use a network provider, which she does. That provider has admitting privileges in a network hospital and in a nonnetwork hospital. If she goes to the nonnetwork hospital she foots at least half the bill. The network hospital could not accommodate AIDS patients, so she was denied admission into the hospital that could treat her. It took us about a month to get that one squared away.

We had a 30-year-old man hospitalized in the final stages of AIDS. He was in an HMO and they decided not to pay for any more hospitalization. They sent him home—and this is quite common for patients to be sent home with agreements between the social worker and a hospital and the insurance plan administrator. He was sent home with nothing but a hand-crank hospital bed. He was totally immobile. He had two care givers, no nursing care provided. Both of the care givers exhausted their leave time from work with the result he laid alone 8 hours a day. They ran home at lunch, but he laid alone unable to turn over 8 hours a day. CWA, my wife, and myself managed to help him during open enrollment, which is the only time he could change to get into the managed care network, and he now has nursing care and is doing a lot better. At the same time, his prescription payments were cut off by the HMO and we had to go around to doctors' offices collecting samples to try to keep him alive.

We have one of our technicians in his middle 50s with a blocked coronary blood vessel. He had a quintuple—which is five; right?—bypass 10 years ago, and the bypass is still clear and healthy. He had two balloon angioplasties to clear the blockage and they did not work. His condition continued to deteriorate to the point of having chest pains at rest and he was diagnosed by his physician with unstable angina. The physician called the managed care doctor to get permission to admit him to Washington Hospital, which was the only place that had the backup facilities. If the first attempted surgery had failed, he would not gain admission. They would not authorize payment. He went home, became increasingly ill, went into Johns Hopkins, with the caveat that if the first attempted surgery at Hopkins was not successful, that they would have to transport him to Washington Hospital for the backup. The plan administrator denied payments for all of those bills. With the help of his physicians, and with the help of Johns Hopkins Hospital, we did manage to get them paid.

Chairman STARK. When does bargaining come up again?

Mr. GERHARDT. God, 1995. It was fun, I will tell you.

Chairman STARK. I don't know whether I like those long contracts or not. But after reviewing your testimony and some of your other problems, I find myself questioning the legality of the actions. Maybe we could get into that later.

Mr. GERHARDT. I would love to.

[The prepared statement follows:]

Testimony of Charlie Gerhardt
Before the Ways and Means Sub-Committee on Health Care
of the United States House of Representatives

March 2nd 1993

in Washington, D.C.

Chairman Stark, Congressmen:

My name is Charlie Gerhardt, my business address is C.W.A. Local 2100, P.O. Box F, Chase, Maryland 21027 and my home address is 8115 Conduit Road, Baltimore, Maryland 21234.

I am the Executive Vice-President of Local 2100 of the Communications Workers of America (C.W.A.) and have held office in the Local for 14 years. The Local represents 1400 communications workers in the Baltimore and Central Maryland area who are employed by the Chesapeake & Potomac (C&P) Telephone Company of Maryland or by AT&T. I am employed by C&P.

My testimony relates the effect that rising health care costs have had on Local 2100 and its members. I believe it's safe to say that my experiences roughly parallel those of C.W.A. members nationwide.

The first major impact of inflated health care costs occurred during 1983 bargaining, during which we sustained a then unprecedented three week strike in order to prevent open ended co-pays on insurance premiums being imposed on our members. We succeeded and began an active campaign to control costs without compromising quality care. That effort continues today. Our efforts have been progressive and well directed but our effect on rising costs has been short term and sometimes at great personal expense to our members and their families.

In 1984 the problem was defined by insurance premiums that were rising at a much greater rate than actual medical costs. The solution was for our employers to become self insured. At the same time we eliminated "double dipping" by families who had redundant insurance and initiated co-ordination of benefits programs. Premium inflation stopped, but costs continued to rise.

We then identified the culprit as hospital costs, so we eliminated coverage for non-emergency weekend admissions, negotiated pre-admission review procedures and outpatient pre-admission testing. Hospital costs continued to rise. When we added mandatory outpatient treatment for certain selected surgical procedures hospital costs dropped for a short time, only to rise again when the hospitals restructured their pricing policies.

Mandatory second surgical opinions did not save a dime. The second opinion always agreed with the first.

We explored and rejected the possibility of "cafeteria" style benefit plans in which participants would pick and choose medical coverage piece meal.

We thought this approach would undermine the financial base of our health care plan as "low users" opted out, leaving no funding to pay for "high users" care. We had a very hard time in 1986 and 1989 bargaining on this issue. C&P Management did go to the "cafeteria" benefits and "high option" coverage has been eliminated for them, which appears to bear out our concerns. Please keep in mind that the difference between a high user and a low user can be the seconds it takes to have a car crash or a heart attack.

It eventually became apparent that even though our employers were self insured, the third party administrators had motive to over pay because they worked for a fixed percentage of the gross expenses. The more expensive the care the more money they made.

In 1989 we were forced to strike for three more weeks on health care issues. That round of bargaining resulted in a very carefully negotiated, custom designed "Managed Care Network" health care plan that was to meet the financial needs of the corporation and the health care needs of our members. It is in effect today.

Our employers remain self insured. The Plan Administrator has a leveraged contract under which they keep a portion of any savings generated and pay a share of any overrun. Medical providers have fixed fee discounted rate schedules. Our members pay huge penalties if they do not use the proper providers or follow the proper procedures.

It is the experience that I have gained in enforcing the terms of our "Managed Care Network" that brings me here today.

I offer the premise that, for any serious health problem, to deny a patient some form of health insurance coverage is to deny treatment. Providers cannot work for free and very few people have the personal financial resources to pay for even a modest amount of medical care.

Health care cost containment is a huge and complex economic problem and I'm afraid that it has a very simple solution. If we deny payment we control costs. By doing so we also deny treatment. This is the current trend in Managed Care, H.M.O.s and traditional indemnified insurance policies and at least in Maryland, Medicaid.

Since 1989, I have gained extensive experience with traditional health insurance, managed care, and H.M.O.s. It has become my job as a union representative to enforce or try to enforce the terms of our member's contracts to pay for health care. I have recovered several hundred thousand dollars worth of claims that were wrongfully denied.

I will outline some of the more dramatic cases.

A retired clerk who was on weekly dialysis treatment for three years was denied reimbursement for several thousand dollars of covered prescription drugs. The pharmaceutical firm threatened to discontinue her supply. She could not pay.

It took me about a month to convince the insurance company that they were responsible and about a year to make them pay. When she died the pharmaceutical firm sued her estate for \$200.00.

The husband of a technician in our Local was poisoned by agent orange in Vietnam and was terminally ill. The technician was very capable and informed regarding our "Managed Care Network". She needed my help only to make sure particular services were covered. For a year and a half she spent at least eight hours a week convincing the plan administrators to meet their obligations. Her husband died.

My wife is a member of C.W.A. and is in her eighth year of full blown A.I.D.S. She is still working. Our managed care guidelines allow us to use only one medical lab. Her monthly bill is about \$450.00 and is fully covered. The Plan Administrator denied payment on the grounds that the lab they required us to use was dishonest, but there were no other labs they would pay for. That took about a month to get straight. She uses a "Network" physician who has privileges at a "Network" hospital and at an "Out-of-Network" hospital. The "Network" hospital cannot treat A.I.D.S. patients. The plan would not pay for treatment in the "Out-of-Network" hospital. They told her to change to an A.I.D.S. specialist who was in the "Network" and had privileges at a Network hospital. There were none. It took about a month to get permission to be treated in the "Out-of-Network" facility.

The husband of a member fell and broke his back. He was hospitalized under full spinal traction and needed an M.R.I. The M.R.I. machine was not available for two days. With no notice, the H.M.O. sent him home where they set up a traction bed in the living room. This was to save two days hospitalization. The patient was immobile, no nurse was provided and the wife lost several days of work before he was rehospitalized. Because it was an HMO there was nothing I could do.

A 30 year old man was hospitalized in the final stages of A.I.D.S. The HMO decided not to pay for anymore hospitalization and sent him home again, with no notice, with nothing but a hand crank hospital bed. He was immobile and his caregivers had used all their leave time. He laid in feces daily. Then he exhausted the annual limit on his prescription coverage.

We collected prescription samples from doctors' offices to keep him alive. Because it was an HMO there was nothing I could do. We helped him change insurance plans during the open enrollment period and he now has a full-time nurse, an electric bed and prescription coverage.

One of our technicians in his mid-fifties had a blocked coronary blood vessel. He had a quintuple bypass 10 years ago, which is still clear and healthy. Two balloon angioplasties failed to clear the obstruction. His condition deteriorated to the point of having chest pains at rest and he was diagnosed with unstable angina. His attending physician was unable to get authorization to operate at Washington Hospital, the only facility with the necessary back up facilities. The patient went home when he should have gone directly to the hospital.

When he continued to deteriorate he entered Johns Hopkins for surgery with a caveat that if complications arose he would have to be transported from the Hopkins O.R. directly to Washington Hospitals O.R.

Our Plan Administrator denied payment for all the services. With the active help of the surgeon and cardiologists we were able to convince them to pay.

My final example is less dramatic but more typical. A retiree had hand surgery that required physical therapy and several different splints as follow-up. All the rules were followed, the services are covered. The Network Administrator will not pay for the therapy. It's only \$300.00 but that's one third of his monthly pension and it's covered care. I'll probably get this one fixed.

I must also include a few of the more common "dirty tricks" insurance administrators use.

- 1.) The contract reads \$5 co-pay on first \$4,000 of prescriptions. What it does not say is that after \$4,000 you have no coverage.
- 2.) The contract provides payment for both acute and chronic care. This seemed to cover the bases until the insurance companies invented "non-acute" conditions which are also "non-chronic" and so they are "non-reimbursable".
- 3.) The contract says you have a three dollar co-pay per prescription, and you get a prescription for a months supply. They'll only authorize distribution of a weeks supply, so you co-pay is really \$12.
- 4.) You have a marginal pap smear, and pap smears are covered. You are told to have one on a semi-annual basis. Five months later you call for an appointment. The soonest you can get one is in six months. This happens a lot.

- 5.) You're having chest pains and shortness of breath, but the contract will not pay for emergency treatment unless you use an H.M.O. doctor. Your phone call is answered by a nurse who tells you that chest pains and shortness of breath do not qualify you to see a doctor. You have to be running a fever. It took us about three hours to get this patient a doctor.
- 6.) The rules state that if a psychologist sees a patient only once, he'll be paid for five visits. If he sees the patient more than once he'll be paid by the visit. If he sees a patient more than five times his fee schedule is reduced.

The point is that for almost every benefit you think you're paying for, someone is writing an administrative practice designed to circumvent their obligations.

The above examples illustrate two major points. Withholding of medical care by insurance providers is widespread. I drew these examples off the top because they are dramatic. I have at least a hundred more and that's only from 1,400 people over a three year period.

Second, these people are at the very top of the health care pecking order. They have high pay, high skill jobs with rich employers and what are considered "first class" medical benefits. And they have a Union to negotiate and act as an ombudsman.

Most people are considerably worse off.

That's the effect of health care costs. I hope I get to participate in the solution.

Respectively submitted,

Charles Gerhardt

Chairman STARK. Mr. Lucassen, how are things with the carpenters?

**STATEMENT OF SIGURD LUCASSEN, GENERAL PRESIDENT,
UNITED BROTHERHOOD OF CARPENTERS & JOINERS OF AMERICA**

Mr. LUCASSEN. Mr. Chairman, my name is Sigurd Lucassen, and I am the general president of the United Brotherhood of Carpenters & Joiners of America, and on behalf of the entire carpentry union membership, I would like to express my appreciation to the chairman for affording me this opportunity to testify on the subject of the economic impact of rising health care costs. Few issues are of more importance and concern to our membership than the rising cost of their care and its impact on their jobs and lives.

The construction industry, in which a majority of our membership works, has historically been an industry in which workers could work hard and, in return, expect fair wages, health care coverage, and a retirement benefit. However, various forces have intervened to change the nature of the industry, and one of the most significant forces has been the rapidly rising cost of health care.

Most of the members in the carpenters union receive health benefits through jointly administered, entrusted multiemployer plans. Almost without exception I can say that there is not a jointly administered health and welfare plan in the construction industry that is not struggling to maintain health care benefits. Most are not winning the struggle. Contract negotiations today involve selecting from among a set of unattractive options designed to divert significant portions of a worker's pay package from wages, training, or pensions to support increasing health care costs. Not only are workers losing health care benefits, but real wages and pension benefits are falling dramatically. And the industry's commitment to fund critically necessary worker training is also faltering as resources are being pulled away from this vital need.

In every section of the country, in every segment of the construction industry, the health care story is the same. Workers are not getting more for more, they are not getting the same for more, rather our members and workers in the construction industry generally are getting less for more; less health care benefits for more money. The end to the downward spiral is not in sight. Despite innovative actions to reduce plan costs we have not stemmed the loss.

Historically, during difficult economic times in the construction industry, every effort was made to avoid benefit cuts in the area of health care. This resistance to health care benefit cuts reflected the tremendous importance of such benefits to our members and their families. No longer can the rising costs of health care be handled by wage concessions or shifts of contributions from retirement benefits to health care. The only option facing our membership is to accept significant benefit cuts, including the most drastic option, the complete elimination of health care benefits. To date, this last option has been a course of action in which only a small percentage of our affiliates have been forced to resort, but such actions, on any scale, reveal the true dimensions of this crisis.

If one wonders how or why the nearly three-fourths of the 37 million without insurance are workers and their families, an examination of the construction industry can provide some insight. In poor construction markets, such as we have experienced in recent years in most parts of the country, competitive pressures on construction users and contractors have meant workers in the industry receive less. The reduction or elimination of health care costs has been the primary basis on which industry participants have sought to reduce worker compensation costs. A recent survey of our affiliate in central Pennsylvania found that only 20 percent of the nonunion contractors in the area provided their employees employer-paid health care benefits. Further, the survey found that no nonunion contractor, not one, provided full family, employer-paid health care coverage. In competitive bidding situations, employers that provide health care coverage are losing jobs to employers who do not offer benefits. The inequities of this system are compounded when surcharges on health care bills cause workers with health care benefits to subsidize the health care cost of employees working for employers who refuse to provide health care protection.

While the details differ from area to area, the formula for addressing rising health care costs is the same: Provide only core health care benefits; eliminate coverage for mental health or drug addiction problems; increase deductibles and copayments for all services received; dramatically increase prescription charges; institute significant new monthly charges for retirees and their spouses who are not Medicare eligible; and increase eligibility standards so workers do not become eligible for benefits until months following the beginning of their employment.

The downward slope of health care benefits cutting is both slippery and steep, with thousands of workers each week losing benefits. And with increasing frequency, the choice confronting a growing number of workers in the construction industry is between their jobs and the retention of health care benefits.

As members of this subcommittee and others inside and out of Congress work for solutions to our health care crisis, I urge you to move with deliberate speed to institute fundamental reform. The tireless efforts of many to grapple with the difficult tradeoff between health care costs and benefits are not providing long-term solutions, rather we are simply managing the steady deterioration of our system of health care.

Again, I thank you, Mr. Chairman and the committee members, for this opportunity to address the issue of crippling economic impact on workers of rising health care costs.

Mr. LEVIN [presiding]. Well, thank you very much. To Mr. Gerhardt, Mr. Sweeney, and Mr. Lucassen, thank you very much for coming.

Mr. Sweeney, I don't think it was included in your testimony today, but in another study that was undertaken by SEIU, there was a discussion of proposals to tax health benefits, and we recently had a chance to review the document and it shows that if there were a cap on the exclusion from taxation of health benefits at \$4,000, that families earning under \$75,000 would pay 75 percent of the tax increase.

There was reference to this a little earlier. Do you want to say anything about that?

Mr. SWEENEY. Well, we are opposed to the taxation of health benefits, and I think the graph you are referring to really shows the dramatic effect that this would have, especially on those who can least afford it. We think that once we have arrived at a national reform of health care that includes a systemic reform addressing cost, quality and access, that there are several financing options that we should be looking at.

Peggy Connerton, who is with me and is responsible for this study, may be able to shed a little more light.

Ms. CONNERTON. We took a careful look at the whole question of what a tax cap, what impact a tax cap would have on middle-income families, and I am sure that you have seen examples of graphs which show that high-income people are the people who benefit the most from this tax exclusion. However, because there are very wealthy Americans earning over \$200,000, if you actually look at the tax burden, who will pay the tax, it will clearly be middle-income families who are forced to pay most of these taxes, and that is what this shows.

So, in effect, a tax cap on health benefits turns out to be regressive and to affect disproportionately certain groups of Americans, particularly those with high health bills, senior citizens, and others. So there are considerable tax inequities as well.

Mr. LEVIN. The chart I have shows that 32.2 percent of the shift in taxation, in essence, would be for families \$20,000 to \$50,000; right?

Ms. CONNERTON. That is correct.

Mr. LEVIN. And a quarter would be families \$50,000 to \$75,000. So even if the moneys were used for a most laudable purpose, say to provide access to families without insurance, even if you could work that out, we would still need to understand that there would be a major shift in tax burden to primarily middle-income families; right?

Ms. CONNERTON. That is correct.

Mr. LUCASSEN. Mr. Chairman, I would like to make a comment on that, because that is a very important subject for those people who work in the building trades. It is a boom or bust industry, and one year you may be fortunate to work 2,080 hours, and the contributions are quite steep and there is more than sufficient money to provide for your coverage, but most funds provide a banking of credits for the next year when there may be no work.

And if we look on that tax basis, we will have a problem with those in penalizing people, the persons who happen to have a good year. But jointly trusted funds try to keep their eligibles as low as possible to cover as many people and they also cover their retirees.

And I could only say to anyone in a political office who attempts to place a tax on health care benefits in the building construction industry, he or she is going to incur the wrath of all our retirees who, I am sure, if those benefits were taxed, there will be steps taken to defer the amount of benefits they do receive.

There are instances where areas have to maintain benefits for their retirees and have diverted the majority of their pension contributions to the health care fund so that the retiree benefits could

be maintained and, therefore, the earnings were decreased and there were no pension increases, but to balance the need between the two.

But I can only say that those individuals who are attempting to tax the health care benefit system as we now know it really should investigate how the system operates, and the operation is really to cover as many people as they can for the most reasonable cost, and that the more employed worker is usually carrying along the individual who did not happen to be as fortunate, whether there was a lack of work, whether the individual is on a temporary disability, but all of those factors are brought into play, and the jointly trusted plans probably are doing their utmost to squeeze the maximum bang for the buck. To tax them is only averting the real true system of getting something where everyone has coverage, whether you are working or whether you are not, because it is a necessary function of government to see that the health care, all its citizens, are provided for.

Mr. LEVIN. Mr. Lucassen, I think that is useful advice. I do believe we need to look at the practical aspects and not kind of grab some theory. What you say about the ups and downs within the construction industry are so true, and maybe a good way to close this hearing is to just mention to you, 30 years it has been now, 30 years ago I represented a joint management-labor fund in the construction industry in Michigan. The average hourly contribution was 10 cents an hour, and I think it is now up to, what, \$2.50, \$3? Within the construction industry the hourly contributions, in many cases, are \$2.50, \$3 an hour, are they not?

Mr. LUCASSEN. That is right.

Mr. LEVIN. That would be an increase of 25 or 30 times in 30 years, and the benefits within that industry are not luxuriant. True, workers were able to get optical coverage and, in some cases, dental coverage like the employer, but they were not, within my experience, in most cases, for frills.

Well, that is the challenge. Thank you all for coming. Again, Mr. Cardin, he expresses his regret. He is at a House Administration meeting. And Mr. Stark and others on the majority side and the minority have questions for you, and if you agree, they will be submitted to you in writing for your answers to be submitted for the record.

Thank you, it has been an informative hearing. The subcommittee stands adjourned.

[Questions submitted to the panelists and responses follow:]



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March 22, 1993

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Ms. Diane Kirkland
Administrative Staff
Committee on Ways and Means
1102 Longworth House Office Bldg.
Washington, D.C. 20515

PANEL TWO

1. In this morning's Washington Post, an article described how employers are controlling cost increases by restricting the providers employees can see and by reducing benefits.

What has been the response of union members to the restrictions on choice inherent in the managed care plans which employers have pushed in the past in their efforts to control health spending?

Restrictions in choice of health care providers was initially a very unpopular and emotionally charged issue. My experience has been that our membership as a whole has adjusted without extreme hardship.

We continue to find provider restrictions to be a problem in the treatment of complex cases. Networks are inadequately staffed with specialists or there are mismatches between physicians and hospitals., e.g. a coronary condition requires laser surgery, but there are no network facilities that can do it.

Physicians sometimes do not understand the rules and inadvertently refer patients out of network.

2. The testimony presented by this panel describes all too clearly the effect of rising costs -- on a human level.

Some have suggested that we delay aggressive cost containment, and allow time to test more innovative approaches.

Can you predict for us what the impact of such an approach might be on the Members you represent?

Cost containment and innovation are neither contradictory nor mutually exclusive. Cost containment is fine unless it interrupts delivery of necessary health care. The American health care system needs major redesign, not political tinkering. C.W.A. has, in my opinion, "maxed out" its ability to "bargain down" costs. If nothing significant changes, we will pay more and fight harder for poorer quality care. Health care for retirees will be unaffordable.

Do you predict continued pressure in labor/management negotiations to cut benefits and eliminate coverage of dependents?

Yes.

3. Could you provide us with examples of the specific proposals put forward by management on health care benefits which have led to strikes?

In 1983, AT&T demanded nationwide co-pays on insurance premiums. If premiums went up more than 14%, the worker would have paid the excess. If memory serves correctly, 14% was the 1982 annual inflation rate for premiums. By the end of the contract we would have been bearing in excess of 28% of the costs. Six hundred and fifty thousand (650,000) people were on strike for three weeks. We did not accept the co-pays.

In 1986 two hundred and fifty thousand (250,000) AT&T workers struck for three weeks to prevent increased deductibles.

In 1989, Bell Atlantic demanded co-pays and "cafeteria style" benefits, along with cuts in benefits for retirees. Fifty-five thousand (55,000) people struck for three weeks. Similar issues in Nynex the same year put 33,000 people on strike for 17 weeks.

In 1992, Bell Atlantic again demanded cost shifting of up to 50% on retirees benefits, with co-pays so large that retirement would become financially impossible for many. Fifty-five thousand union members worked to rule for three weeks. According to C.E.O. Ray Smith, the economic impact was worse than a strike.

6. Mr. Gerhardt, I want to clarify a point that I'm a little unclear about.

Your testimony includes a number of fairly dramatic, possibly fraudulent examples of tactics used by plans to deny payments in order to control costs.

You're not suggesting that we discontinue efforts at cost containment, are you?

Please note that cost shifting is not the same as cost containment.

C.W.A. has been bargaining cost containment measures for ten years. They are absolutely essential. It is also important to note that while we succeeded in reducing specific costs, overall costs continued to rise drastically, largely as a result of the health care industry defending itself from containment tactics.

The only containment measures I would rule out are those that result in abatement of quality care.

Fraudulent or marginal practices by insurance plan administrators will continue as long as such practices are profitable. For example: When a plan administrator is compensated at a percentage of the gross claims, the tendency is to defraud the payor, since the higher the gross the higher the income for the administrator. In an indemnified insurance plan, HMO, or third party leveraged administrative contract, the tendency is to defraud the payee or the health care consumer. The lower the cost the higher the profit.

Would your advice be that we seek ways to protect covered individuals when plans are financially at risk for managing health care services?

I'm not sure I understand this question, but here goes.

Protecting covered individuals from at risk plans is a band-aid approach. We need to design a system that eliminates the risk.

SERVICE EMPLOYEES

INTERNATIONAL UNION, AFL-CIO, -CLC

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JOHN J. SWEENEY
INTERNATIONAL PRESIDENT

RICHARD W. CORDTZ
INTERNATIONAL SECRETARY-TREASURER

March 29, 1993

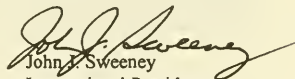
Diane Kirkland
Administrative Staff
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Ms. Kirkland:

Attached are SEIU's responses to the questions submitted by the Subcommittee on Health of the Committee on Ways and Means to be included in the hearing record of March 2, 1993 on "Health Care Reform: The Economic Impact of Rising Health Care Costs."

Thank you for your continued interest in SEIU's perspective on the healthcare cost crisis and the need for reform.

Sincerely,


John J. Sweeney
International President

attachments

Responses to first series of questions.

Question 1. Reaction to restricting choice of providers.

Numerous polls and surveys have indicated that people want to be able to choose their own healthcare provider. --- poll results?

SEIU represents nearly half of the workers enrolled in California's large health benefits program known as CalPERS. Enrollees can choose from more than two dozen health plans, the majority of which are HMOs. According to a 1991 PERS consumer experience survey, the most cited reason for selecting a healthcare plan was the ability to choose one's own physician. The next most cited reason, the cost of the plan, came in a distant second.

But not all managed care arrangements are alike; some provide for greater choice among health providers than others. Generally, the higher the level of choice, the more satisfied people are with their healthcare plans.

Question 2.A. Impact of delaying cost containment.

There is no question that we must pursue an aggressive approach to cost containment now, rather than at some point down the road. Our members have already given up too much due to out of control health costs -- they've had to accept lower wages, reductions in other benefits, and an overall decline in their standard of living. Working people cannot afford a continuation of this calamitous trend. Strict cost containment measures must be put in place without delay. Without cost controls, healthcare reform will be meaningless.

Question 2.B. Pressure on negotiations.

Disputes over health benefits have been the leading cause of major strikes in recent years, and there is no sign that this trend will change in the absence of comprehensive national healthcare reform with strong cost controls. Every time union members sit down at the bargaining table, they face ever-mounting pressure from management to cut benefits or shift additional costs onto workers in the form of higher premiums, deductibles and copayments.

It is not uncommon that union members pay over \$200 a month, or \$2,400 a year for their share of the premium for family coverage. Then after taking into account deductibles and other copayments, insured workers may easily spend over \$5,000 a year for basic health coverage for their families. With costs this high, many workers can no longer afford to provide health insurance for their families. That's why each year more and more working families are joining the ranks of the uninsured.

Question 3. Management healthcare proposals that led to strikes.

Disputes over health insurance have brought increasing numbers of SEIU members to the picket lines in recent years. In one case, SEIU members at a nursing home in Indiana waged a 147-day strike to win health insurance coverage from their employer. When these workers returned to work, they not only had their health insurance but the employer assumed the full cost of coverage.

A number of SEIU locals representing healthcare workers throughout Pennsylvania have been forced to strike to protect the viability of their health and welfare funds. Typically, the employers have threatened to cap the contribution to the fund, despite double-digit annual increases in the cost of providing benefits. In such instances, workers either would suffer a reduction in benefits or have to pay the difference out of pocket. SEIU locals experienced mixed outcomes from these strikes -- further indication that health benefits bargaining has become a no-win situation.

Question 5. Bargaining for health benefits over wages.

Union members are well aware of the devastating effects that medical bills can have on a family. They've watched as their neighbors and friends have had to sell everything, including their homes, to pay for expensive medical treatments that their cut-rate insurance plans failed to cover. Our members are scared they may confront the same fate. So when the trade off is between a steady, gradual decline in their standard of living versus the peace of mind that a serious illness will not lead to bankruptcy, they're willing to concede to lower wages.

Responses to second series of questions.**Question 1. Medical services or coverage willing to forgo for cost containment.**

There is a mistaken notion that healthcare cost containment must necessarily lead to a reduction in benefits or services. All we have to do is look to the experiences of our international competitors to see that this need not be the case. To cite a few examples, Germany, Japan, Canada and Sweden have all achieved comprehensive, universal healthcare coverage at a cost considerably below what the United States spends. The experiences of these countries demonstrate that it is possible to control health costs without having to sacrifice quality or service. We just need to spend our healthcare dollars more wisely.

Question 2. Views on managed competition.

Managed competition can take on several different forms. The pure managed competition theory assumes that the ability of informed consumers to switch health plans will lower costs and improve quality through competition among health plans for new enrollees. But the CalPERs program, which is often referred to as a working model of managed competition, provides little evidence for the contention that people choose their health plans based on cost. Rather, the evidence

suggests that geographic location and consumer satisfaction measures, such as the ability to choose one's physician are important contributors to healthcare decisions. Sophisticated market institutions, including consumer information systems and the risk-adjusting of premiums are necessary to give consumers dependable price signals.

The CalPERS experience also indicates that managed competition alone does not constrain soaring health costs. These findings are supported by the Congressional Budget Office, which recently concluded that managed competition, by itself, would produce no cost savings for at least five years. Cost controls such as a national budget and/or rate controls are necessary to produce significant cost savings.

Question 3. Taxation of benefits.

A negative aspect associated with certain managed competition proposals is the plan to tax health benefits. In theory, the tax is viewed as an incentive for consumers to switch into less costly managed care plans. But in reality, the added financial burden caused by taxing benefits falls disproportionately on lower- and middle-income workers. Families earning under \$75,000 will pay three-quarters of the tax increase. To make a managed competition plan equitable, taxation of health benefits should not be incorporated into the package.

Consumers can be made more cost conscious purchasers of health care without resorting to taxing their benefits. But they need access to better information. Consumers are handicapped by the lack of information from which to make informed choices. People must have access to consumer satisfaction ratings and other information that allows them to make informed plan comparisons.

Furthermore, consumer representatives should be given a major role in governance of health plan purchasing arrangements. Under the CalPERS program, for example, consumers have a strong voice on the purchasing cooperative's board and, as a result, the board has followed its mandate to protect consumers against high costs.

SUBMISSIONS FOR THE HEARING RECORD OF MARCH 2, 1993 ON HEALTH CARE REFORM: THE ECONOMIC IMPACT OF RISING HEALTH CARE COSTS

QUESTIONS AND ANSWERS FOLLOWING SIGURD LUCASSEN'S PRESENTATION ON BEHALF OF THE UNITED BROTHERHOOD OF CARPENTERS

Q. What has been the response of union members to the restrictions on choice inherent in the managed care plans which employers have pushed in the past in their efforts to control health spending?

Our membership has attempted to resist the option of restrictions on choice in regards to the selection of a health care provider, but in many of our members' plan just such an action has been taken. Whenever you limit the freedom of choice in the health care area, there's resistance, but it's proven to be a necessary change to protect the quality and range of health care services provided by our members' plans.

Q. Can you predict for us what the impact of such an approach might be on the Members you represent?

First, I think there needs to be real and immediate cost containment actions. A failure to control the rapid rise in health care costs will result in workers losing health care benefits entirely. Innovative measures to restrain costs, deliver care more efficiently, and promote preventive health care measures need to be pursued, but in the short term, the brakes must be applied to health care cost increases.

Q. Do you predict continued pressure in labor/management negotiations to cut benefits and eliminate coverage of dependents?

I can say with complete confidence that there will be continued pressure in labor-management negotiations to cut benefits and limit the coverage of the negotiated benefits. In the absence of a comprehensive response to the health care cost crisis, contract negotiations will increasingly be focused on the only sure way for an employer to cut costs, by cutting benefits. Employers whose workforces work under collective bargaining agreements, will face escalating competitive pressures from competitors that have no collective bargaining obligations and who provide minimal or no health care coverage. This is particularly true in the construction industry which is characterized by numerous relatively small companies that aggressively resist the imposition of an employee health care benefit obligation.

Q. In competitive bidding situations, employers offering health benefits are losing contracts to those who do not? What effect has this had on coverage?

Unionized employers in the construction industry that provide employees health care benefits are at a serious competitive disadvantage relative to nonunion competitors. The health care costs incurred by union contractors alone can be the difference in whether a project bid is successful or not. Employers in this competitive environment inevitably seek a range of cost reductions which may include wage, pension or health care costs reductions. Health care costs have been the primary target in recent years of employers cost cutting efforts. This is due to the rapidly escalating costs and the fact that the cost of the health care benefit is a significant percent of the overall labor costs of a contractor.



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Q. Why do your members urge you to bargain for decent health benefits, at the expense of wages?

The reason is very simple. It is critically important to our membership that they maintain insurance coverage for their health care needs. If maintaining health coverage requires foregoing wage increases, and it does, the membership opts for that approach. The explosion of health care costs compels workers to accept wage freezes and cuts in order to maintain some core health care benefit. Significant limitations on coverages, significant increases in employee payments for health care coverage, are not alternatives workers can afford to accept. Wage cuts in this context are the lesser of two evils.

[Whereupon, at 12:32 p.m., the hearing was adjourned.]
[A submission for the record follows:]

**STATEMENT OF THE
TRADE ASSOCIATION HEALTHCARE COALITION
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE
MARCH 2, 1993**

We appreciate the opportunity to present testimony for this hearing on Health Care Reform. As we seek to address the problems facing health care in America, we must take note of things that are working well and serving the public in an efficient and effective manner.

We are a coalition of trade associations which, as one of our many services to our members, have been providing health insurance coverage for many years to small businesses. We are bona fide business associations, quite apart from those whose main purpose is to sell health insurance. We do not skim, cherry pick, or cover only the safest risks. We offer insurance to all of our members, and are willing to adjust to most of the proposals under consideration as long as they are applied uniformly to all other insurance offerings. We are strong supporters of cost containment, of greater access to health care for the uninsured, and of medical liability reforms.

The issue that we wish to present to this Committee for its consideration is a comparatively small one, in the overall scheme of these reform proposals, but it is one that is important to a large group of American workers who belong to group health plans.

We are concerned about proposals that would limit the ability of our association members to offer meaningful health care programs to the small businesses which they represent. We are pleased to note that Chairman Stark's bill of last year exempted legitimate association plans, as did Senator Bingaman's and Senator Durenberger's bill. Both of these provisions were intended to continue association plans despite the other reforms to our health care system.

Legitimate trade associations have demonstrated that they are uniquely qualified to serve their members in meeting health insurance needs. They have been major contributors to the health care delivery system, providing a method for millions of small businesses to pool risks and increase market leverage for their employees. We provide a service quite similar to large employers and wish to be treated as such in any proposed changes in the delivery system.

Our members distinguish themselves from others who do not have this history of serving small businesses. The associations we represent speak only for themselves, not for insurance companies, not for MEWA's, and not for the myriad insurance groups which call themselves associations but in reality are nothing more than insurance sales vehicles.

We appreciate the opportunity to participate in this debate. We can demonstrate to the Congress and the Administration that associations are a necessary and valuable health insurance resource.



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